

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A BULL ING _____ B WING _____	(X3) DATE SURVEY COMPLETED 05/09/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	X5. COMPLETE N DATE
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W 000 INITIAL COMMENTS	<p>A recertification survey was conducted from May 8, 2013 through May 9, 2013. A sample of three clients was selected from a population of six females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000		
W 249 483.440(d)(1) PROGRAM IMPLEMENTATION	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to encourage and facilitate implementation of clients program of placing the place mat on the dining room table prior to dinner and failed to ensure communication devices were made available, for</p>	W 249		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES
Constance A. Reese Program Director TITLE
5/31/13 (XB) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 249	<p>Continued From page 1</p> <p>two of three clients in the sample. (Clients #1 and #3)</p> <p>The finding includes:</p> <p>1. Facility staff failed to encourage and facilitate implementation of Client #1's program of placing the place mat on the dining table prior to dinner, as follows:</p> <p>Evening observations on May 8, 2013, at 4:45 p.m., revealed Client #1 was taken to the bathroom to wash her hands for dinner. Moments later, Client #3 was observed to place mats on the dining table for dinner. At approximately 5:55 p.m. after dinner, interview with direct support professional #2 (DSP2) revealed that Client #1 had a training program to place the place mat on the table prior to breakfast and dinner. Further interview with DSP2 revealed that the goal was not implemented. When asked, DSP2 stated that Client #3 usually set the table. DSP2 further revealed that she should have implemented Client #1's program on May 8, 2013.</p> <p>On May 9, 2013, beginning at 10:24 a.m., review of Client #1's individual support plan (ISP) dated September 7, 2012, revealed the client had a formal program to improve her activities of daily living (ADL) skills by placing the mat on the table for breakfast and dinner three days a week with verbal prompts.</p> <p>On May 9, 2013, the relief manager #1 (RM1) and QIDP1 were interviewed at 12:20 p.m. and 1:44 p.m., respectively. They both confirmed that the aforementioned program should have been</p>	W 249	<p>1. DSP Staff will receive training on how to implement Client #1 program goal to improve her ADL skills of placing mats on the table before breakfast and dinner three times weekly using verbal prompts. OIDP and Residential Manager will monitor weekly and check documentation for implementation.</p>	6/14/13
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	<p>W 249 Continued From page 2 implemented on May 8, 2013, prior to dinner.</p> <p>2. The facility staff failed to ensure consistent use of Client #3's communication device, as evidence below:</p> <p>On May 8, 2013, at 7:44 am., Client #3 was observed hitting all the buttons on her communication device. When the client hit the button to go to a fast food restaurant, direct support professional #1 (DSP1) said they would go on a weekend. Day program observation from 10:36 a.m. through 11:00 am. revealed Client #3 was engaged in table top activities. For example, Client #3 was engaged in an activity to identify numbers. The client was also observed to assemble a word puzzle. During this time, the communication device was not observed. At 3:38 p.m., Client #3 arrived home from the day program. At 3:48 p.m., DSP4 asked the client to set the table. At 3:53 p.m., the client was offered different choices for snack. At 4:09 p.m., DSP4 presented dominoes for Client #3 to play. At 4:52 p.m., DSP4 asked the client to pour the water for dinner. At 5:05 p.m., Client #3 gestured for more food during dinner. At no time was the client's communication device observed after she exited the facility for the day program at 8:59 a.m.</p> <p>On May 9, 2013, at 11:12 a.m., review of the client's speech and language evaluation dated March 25, 2012, revealed the client will use a voice output device to communicate with persons in her environment. Further review revealed the following objective:</p> <p>a. Client will make her wants and needs known (bathroom, eat, van, drink, home).</p>	W 249	<p>2.The Speech and Language Pathologist will provide training for DSP Staff at the home and day program on daily usage of communication device for Client #3. QIDP and Residential Manger will visit day program monthly and monitor active treatment documentation to ensure the communication device is part of Client #3's daily activities at day program and home.</p>
			(5) COMPLETION DATE 6/14/13

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W 249	Continued From page 3 b. Client will make choices in ADL (Activities of Daily Living) activities (clothing, exercise, leisure) In an interview on May 9, 2013, at 1:30 p.m., the qualified intellectual disabilities professional #1 (QI DP1) revealed that the communication device is kept in a black bag during transportation to the day program. Continued interview indicated that the communication device should be made available to the client to communicate her needs while at the day program and at home.	W 249		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly, for one of the three shift of duty reviewed (weekday 8:00 a.m - 4:00 p.m.). The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On May 8, 2013, at 12:14 p.m., interview with relief manager #1 (RM1) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday. Review of the facility's fire drill records on May 8, 2013, beginning at 12:19 p.m. revealed that no	W 440	Quarterly fire drills will be conducted for the 8am-4pm shift weekdays and weekends. Residential Manager will review documentation to ensure a minimum of four a year for this shift.	6/14/13

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W 440	Continued From page 4 drills were held during the weekday shift on 8:00 a.m. - 4:00 p.m. from July 2012 through December 2012. At approximately 12:42 p.m., RM1 looked through the fire drills with the surveyor. RM1 then acknowledged that fire drills were not conducted during the weekday shift (8 a.m. - 4:00 p.m.) from July 2012 through December 2012.	W 440		
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2013
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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 9, 2013 through May 10, 2013. A sample of three residents was selected from a population of six females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000		
I 090	<p>3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHID) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The finding includes:</p> <p>Observation during the inspection of the environment on May 9, 2013, beginning 2:34</p>	I 090		

Health Regulation & Licensing Administration

Christine A. Reese Program Director TITLE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE
5/31/13

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1090	<p>Continued From page 1</p> <p>p.m., revealed the following:</p> <ul style="list-style-type: none"> - There were observed water stained ceiling tiles located in the bathroom on the second level and in the kitchen area. - There was an approximate 8 to 10 inch tear in the carpet located directly in front of the basement door which posed a potential safety hazard. - There was observed peeling/chipping drywall (right side) located at the top of the stairs leading to the basement. - The basement screen door was observed without a door handle. The door screen was also observed to be missing. - The floor tile located in the basement bathroom was observed to be heavily stained. - There was an approximate 12 inch open area observed near the second step leading from the kitchen to the back yard which was a place for potential rodents to reside. <p>Relief Manager #1 (RM1) who was present during the inspection, confirmed the above findings. RM1 stated she would address the findings with maintenance.</p>	1090	<ol style="list-style-type: none"> 1. Water stained ceiling tiles will be replaced in the 2nd floor bathroom and kitchen area. 2. Carpet will be replaced in from of basement door. 3. Drywall located at the top of the stairs leading to the basement will be sealed and repainted. 4. Basement screen door was replaced to include handle and screen. 5. The floor tile located in basement bathroom will be cleaned to remove heavy stains. 6. 12 inch open area will be closed leading from kitchen to backyard. 	<p>6/7/13</p> <p>6/7/13</p> <p>6/7/13</p> <p>5/15/13</p> <p>6/7/13</p> <p>6/7/13</p>
1135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by:</p>	1135		

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	<p>1135 Continued From page 2</p> <p>Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to hold evacuation drills quarterly, for one of the three shift of duty reviewed (weekday 8:00 a.m. - 4:00 p.m.).</p> <p>The finding includes:</p> <p>The GHIID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On May 8, 2013, at 12:14 p.m., interview with relief manager #1 (RM1) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and 12:00 a.m. - 8:00 a.m.), Monday through Friday.</p> <p>Review of the GHIID's fire drill records on May 8, 2013, beginning at 12:19 p.m. revealed that no drills were held during the weekday shift on 8:00 a.m. - 4:00 p.m. from July 2011 through December 2012. At approximately 12:42 p.m., RM1 looked through the fire drills with the surveyor. RM1 then acknowledged that fire drills were not conducted during the weekday shift (8 am. - 4:00 p.m.) from July 2012 through December 2012.</p>	1135	Cross Reference W440	6/14/13
	<p>1422 3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that resident's training objective was implemented</p>	1422		

Health Regulation & Licensing Administration

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1 422	Continued From page 3 in accordance with their individual support plan (ISP), for two of the three residents included in the sample. (Residents #1 and #3) The findings include: 1. Facility staff failed to encourage and facilitate implementation of Resident #1's program of placing the place mat on the dining table prior to dinner, as follows: Evening observations on May 8, 2013, at 4:45 p.m., revealed Resident #1 was taken to the bathroom to wash her hands for dinner. Moments later, Resident #3 was observed to place mats on the dining table for dinner. At approximately 5:55 p.m. after dinner, interview with direct support professional #2 (DSP2) revealed that Resident #1 had a training program to place the place mat on the table prior to breakfast and dinner. Further interview with DSP2 revealed that the goal was not implemented. When asked, DSP2 stated that Resident #3 usually set the table. DSP2 further revealed that she should have implemented Resident #1's program on May 8, 2013. On May 9, 2013, beginning at 10:24 a.m., review of Resident #1's individual support plan (ISP) dated September 7, 2012, revealed the resident had a formal program to improve her activities of daily living (ADL) skills by placing the mat on the table for breakfast and dinner three days a week with verbal prompts. On May 9, 2013, the relief manager #1 (RM1) and QIDP1 were interviewed at 12:20 p.m. and 1:44 p.m., respectively. They both confirmed that the aforementioned program should have been implemented on May 8, 2013, prior to dinner.	1422	Cross Reference W249 (1)	6/14/13

Health Regulation & Licensing Administration

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I 422	Continued From page 4 2. The GHIID staff failed to ensure consistent use of Resident #3's communication device, as evidence below: On May 8, 2013, at 7:44 a.m., Resident #3 was observed hitting all the buttons on her communication device. When the resident hit the button to go to a fast food restaurant, direct support professional #1 (DSP1) said they would go on a weekend. Day program observation from 10:36 a.m. through 11:00 a.m. revealed Resident #3 was engaged in table top activities. For example, Resident #3 was engaged in an activity to identify numbers. The resident was also observed to assemble a word puzzle. During this time, the communication device was not observed. At 3:38 p.m., Resident #3 arrived home from the day program. At 3:48 p.m., DSP4 asked the resident to set the table. At 3:53 p.m., the resident was offered different choices for snack. At 4:09 p.m., DSP4 presented dominoes for Resident #3 to play. At 4:52 p.m., DSP4 asked the resident to pour the water for dinner. At 5:05 p.m., Resident #3 gestured for more food during dinner. At no time was the resident's communication device observed after she exited the GHIID for the day program at 8:59 a.m. On May 9, 2013, at 11:12 a.m., review of the resident's speech and language evaluation dated March 25, 2012, revealed the resident will use a voice output device to communicate with persons in her environment. Further review revealed the following objective: a. Resident will make her wants and needs known (bathroom, eat, van, drink, home). b. Resident will make choices in ADL (Activities of	I 422	Cross Reference W 249 (2)	6/14/13	

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1422	Continued From page 5 Daily Living) activities (clothing, exercise, leisure) In an interview on May 9, 2013, at 1:30 p.m., the qualified intellectual disabilities professional #1 (QIDP1) revealed that the communication device is kept in a black bag during transportation to the day program. Continued interview indicated that the communication device should be made available to the resident to communicate her needs while at the day program and at home.	1422		
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