

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  A recertification survey was conducted from January 17, 2012 through January 20, 2012. A sample of three clients was selected from a population of five women with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process.  The findings of the survey were based on observations in the home and at two day programs, interview with one client's guardian, staff at the home and at the two day programs, as well as a review of client and administrative records, including incident reports.  [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services meet the needs of each client, for one of the three clients in the sample. (Client #2)  The finding includes:  On January 18, 2012, beginning at 11:48 a.m., Client #2 was observed drooling heavily, as the day program staff assisted her with a recognition assignment. At 11:49 a.m., the day program staff handed Client #2 a paper towel and asked her to	W 120		

*Received 3/7/12*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Shirley Mason, Director of Residential Services* TITLE  
DATE *2/23/12* (X6) 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.

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	Continued From page 1 wipe her mouth. The client did not respond therefore the direct support staff wiped her mouth with hand over hand assistance. Continued observation revealed the direct support staff placed the paper towel on the table several times as she wiped her mouth repeatedly with the same paper towel. At 12:15 p.m., the day program staff threw the soiled paper towel away then assisted the client to the cafeteria for lunch.  On January 18, 2012, at 9:00 a.m., review of Client #2's physician order dated November 26, 2011, revealed the client was a hepatitis B carrier.  Interview with the day program case manager on January 18, 2012, at approximately 12:30 p.m., revealed the day program staff was required to put the paper towel in the trash after Client #2's mouth was wiped.	W 120	55 <sup>th</sup> Street Survey Responses February 20, 2012  W120  The QIDP will meet with the day program to discuss this training concern. The QIDP will ensure that the staff is retrained on proper infection control practices with emphasis on managing the drooling tendency of Client #2. Training will be documented and MTS will maintain copies...3-2-12 Additionally the QIDP and facility manager will visit the program at minimum monthly and will observe for ongoing compliance. Issues seen will be reported to the day program management staff...3-1-12		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that injuries of unknown origin were reported immediately to the State Survey Agency (SSA) timely, for one of the three clients included in the sample. (Client #1)	W 153			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 153	Continued From page 2  The finding includes:  Review of the facility's incident reports on January 17, 2012, at 10:30 a.m., revealed that on January 3, 2012, Client #1 was seen in the emergency room for a swollen hand. The emergency room report revealed that the client's finger was fractured.  An interview was conducted with the qualified intellectual disabilities professional (QIDP) on January 20, 2012, at 10:30 a.m., to ascertain information regarding the facility's incident management system. According to the QIDP, all incidents of unknown origin should be reported immediately to the State survey agency. Review of the incident report, however, revealed that the state agency was notified two days after the incident was reported.	W 153	W153  MTS initially discovered the injury between 5pm and 6pm on the 3 <sup>rd</sup> of January. A reportable incident was developed and submitted within 24 hours on the 4 <sup>th</sup> of January. The fracture was discovered based on the x-ray results obtained on 1-4-12. The QIDP upgraded the incident from reportable to serious reportable on 1-5-12 and reported to the licensing agency via email and via a faxed incident report. MTS believes that both the initial reportable incident and the upgrade to serious reportable based on better information (the x-ray) were submitted within 24 hours as per the mandate...2-20-12		
W 155	483.420(d)(4) STAFF TREATMENT OF CLIENTS  The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days of all incidents, for one of the five clients residing in the facility. (Client #1)  The finding includes:  On January 17, 2012, at 10:30 a.m., review of	W 155			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 156	Continued From page 3 Client #1's incident report dated January 3, 2012, revealed a direct support staff discovered Client #1's left hand was swollen. Review of another incident report dated January 5, 2012, at approximately 10:35 a.m., revealed the client had an x-ray on January 4, 2012. Continued review revealed the client sustained a fractured finger.  Further review of Client #1's incident reports revealed no evidence of an investigation for the aforementioned incident. Interview with the qualified intellectual disabilities professional (QIDP) on January 17, 2012, at 5:17 p.m., revealed the investigation was "pending" and it will be completed the next day. On January 19, 2012, at approximately 10:00 a.m., the QIDP gave the surveyor the investigation report. Review of the investigation report, revealed Client #1 may have fractured her hand after displaying an "explosive behavior". Further review revealed "the actual date of this occurring cannot be substantiated."  Interview with the facility's QIDP on January 19, 2012, at approximately 10:30 a.m., confirmed the incident took place on January 3, 2012, and that the ensuing investigation was completed on January 18, 2012.  At the time of the survey, the facility failed to provide evidence that the administrator was notified of the results of the investigation within five working days, as required by federal regulation.	W 156	*The Director of Residential Services will meet with the QIDP to reinforce the importance of submitting incident reports within 24 hours, including situations where the status of an incident changes. Reporting of incidents is systematically tracked for ongoing compliance and issues are reviewed with the QIDP during monthly meetings with the Director...3-1-12  W156		
W 186	483.430(d)(1-2) DIRECT CARE STAFF  The facility must provide sufficient direct care staff to manage and supervise clients in	W 186	It took the investigator more than 5 days to try to ascertain the cause of the fracture. Even after taking the extra time, it could not be determined for certain exactly how the fracture occurred although the review process makes a self-injury based on banging her hand most likely. In the future, the IMC will track the five-day timeline and ensure that licensing receives a report within the prescribed 5 days. If the investigation continues beyond the 5 days and results in better, more accurate findings, the IMC will ensure that the updated report is also submitted to licensing...3-1-12  W186		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 186	<p>Continued From page 4 accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is not met as evidenced by: Based on interviews, and record verification, the facility failed to ensure adequate direct care staff was scheduled on each shift to supervise the clients in accordance with their assessed needs for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>[Cross refer to W322.1] The facility failed to ensure sufficient direct care staff were on duty to provide timely completion of Client #2's neurology appointment.</p> <p>Interview with the residential director (RD) and the registered nurse (RN) on January 19, 2012, at 3:00 p.m., revealed Client #2's follow-up neurology appointment was scheduled for December 29, 2011; however, the neurology office called to reschedule the appointment for January 2012. The RD indicated that the appointment time offered conflicted with the time residents are transported from their day programs. Therefore, a new appointment was obtained for the next available appointment date, March 5, 2012 (three months later).</p> <p>The facility failed to ensure adequate staff was scheduled to facilitate the timely completion of Client #1's recommended neurology consultation.</p>	W 186			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each staff was effectively trained to meet the needs of one of three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>The facility failed to ensure that each staff received ongoing training on Client #1's intake and output documentation, as evidenced below:</p> <p>On January 19, 2012, at 3:37 p.m., review of Client #1's intake and output records for October, November and December 2011 revealed five of thirteen weekly intake and output forms reviewed were not dated.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) and the residential director (RD) on January 20, 2012, at 11:02 a.m., acknowledged the finding and confirmed that the date of all intake and output should be recorded for Client #1. They also revealed that all direct care staff had been trained on the client's health management care plan, which included how to document the client's fluid intake and output. The RD indicated that she is required to monitor the information staff documents on the intake and output forms daily. The QIDP stated that she coordinates with the RD, and may monitor the</p>	W 189		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012	
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	<p>Continued From page 6 intake and output forms if the RD is not on duty.</p> <p>On January 19, 2012, 3:53 p.m., record review revealed staff training on Client #1's health management care plan, which included interventions on how to monitor the client's intake and out put protocol.</p> <p>At the time of the survey, there was no evidence the training provided was adequate to ensure that staff documented the required information at all times.</p>	W 189	<p>In the future, MTS will bring on extra staff and make transportation arrangements to ensure that needed medical appointments are kept when they need to be scheduled in a "difficult window" (like day program delivery and pick up times). The QJDP and assigned RN will notify the Director of Residential Services and DON in advance so that proper arrangements can be made...3-1-12</p> <p>MTS will ensure that the March 5<sup>th</sup> date is kept. It should be noted that Client #2 has shown significant improvement since an adjustment in her medication reglmen was made...2-20-12</p>	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventive services were provided for two of three clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. The facility failed to ensure Client #2 received timely follow-up to address her frequent syncope episodes.</p> <p>a. On January 17, 2012, beginning at 10:00 a.m., review of Client #2's incident reports revealed she was unresponsive and taken to the emergency room (ER) six times, between May 15, 2011, and November 24, 2011. Three of the six ER visits resulted in hospital admissions for further evaluation. Record review on January 18, 2012,</p>	W 322	W189	

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	<p>Continued From page 7</p> <p>beginning at 10:00 a.m., revealed that during the aforementioned ER visits/hospitalizations, the client was recommended to be evaluated by cardiology and neurology. Continued record review revealed the following information regarding the specialty visits.</p> <p>On January 19, 2012, at 3:00 p.m., record review revealed Client #2 was hospitalized from November 23, 2011 through November 25, 2011 for altered mental status. Review of a primary care physician (PCP) progress note dated November 29, 2011, following the hospitalization, revealed the client was evaluated and continued neurology follow-up was recommended for syncope</p> <p>Interview with the residential director (RD) and the registered nurse (RN) on January 19, 2012, at 3:00 p.m., revealed Client #2's follow-up neurology appointment was scheduled for December 29, 2011; however, the neurology office called to reschedule the appointment for January 2012. The RD indicated that the appointment time offered conflicted with the time residents are transported from their day programs. Therefore, a new appointment was obtained for the next available appointment date, March 5, 2012 (three months later).</p> <p>At the time of the survey, the facility failed to ensure the client's neurology follow-up was conducted timely as recommended.</p> <p>b. A post ER PCP medical progress note dated June 30, 2011, revealed Client #1 was evaluated at the ER for altered mental status. The PCP recommended follow-up by the cardiologist and</p>	W 322			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 56TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	<p>Continued From page 8</p> <p>neurologist. The client returned to the ER on July 14, 2011 and was admitted for syncope. Review of the discharge summary dated July 18, 2011, revealed an EEG was performed and it was unclear what the results showed. The neurological consultation report dated July 28, 2011, revealed the client was evaluated for episodes of loss of consciousness and possible dystonia. The report further revealed that medication could be prescribed to treat the dystonia; however, a sleeping EEG must first be conducted. In the consultation report dated, July 28, 2012, the neurologist also referenced the EEG conducted at the hospital on July 14, 2011, stating that it concluded there was significant motion artifact. The report further revealed that the client "may eventually need another EEG study under sedation." A consultation report dated August 23, 2011, confirmed that a sleeping EEG was attempted. The impression revealed it was probably within normal limits, however, a sleep EEG may be useful in clarifying the study further.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) and the nurse on January 19, 2012, at 3:02 p.m. revealed that the sleeping EEG recommended on August 23, 2011, had not been addressed by the PCP for Client #2.</p> <p>2. The facility failed to ensure that Client #1's serum sodium level was monitored monthly as recommended.</p> <p>On January 17, 2012, at 9:07 a.m., Client #1 was observed to be significantly overweight for her height. Interview with the medication nurse at 9:13 a.m., revealed the client had gained a lot of</p>	W 322			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	<p>Continued From page 9</p> <p>weight during the last year, however, the cause had not been determined. Interview with the QIDP at 9:58 a.m., revealed that numerous studies had been performed to monitor the client's condition and to address her weight gain.</p> <p>On January 18, 2012, at 2:32 p.m., review of a nephrology consultation dated February 3, 2011 revealed that Client #1 was being monitored by the nephrologist for her diagnosis of nephrogenic diabetes insipidus. The consultation report revealed that the client was evaluated for weight gain, shortness of breath, nephrogenic diabetes insipidus, and hypothyroidism. The nephrologist recommended to decrease the client's fluid intake to 3 liters per day, and to monitor sodium twice weekly, then monthly. Review of the followup nephrology consultation report dated July 7, 2011, revealed to continue to monitor the client's labs monthly. Record review revealed no monthly lab values were available for the months of April, May, July, September, and October 2011, to confirm that the client's sodium had been monitored monthly as recommended.</p> <p>Interview with the director of nursing (DON) on January 19, 2012, at 3:30 p.m., revealed that the primary care physician approved the nephrologist's recommendations for Client #1, and that they were being implemented. Further discussion with the DON revealed that she would follow-up with the primary care physician (PCP) and the nurses at the administrative office to determine if lab results were available for the aforementioned months. On January 20, 2012, at 11:30 a.m., the DON acknowledged that her discussion with the PCP and the nurses revealed no additional lab reports</p>	W 322		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 10 were available for the client. At the time of the survey, there was no evidence that Client #1 received the lab tests during the months of April, May, July, September, and October 2011, as recommended.	W 322	The Facility Manager will review the data for Client #1's intake and output at minimum 5 days weekly and the QIDP will review the data at minimum 3 times weekly. Issues discovered will be addressed with staff either on the spot or on their next scheduled shift...3-1-12 The QIDP and Facility Manager conducted a training session before the end of the survey addressing this concern...1-20-12 The issue was also addressed in the February 2012 all staff meeting...2-3-12	
W 331	<b>483.460(c) NURSING SERVICES</b>  The facility must provide clients with nursing services in accordance with their needs.  This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility's nursing staff failed to provide each client with services in accordance with their needs, for one of three clients in the sample. (Client #1)  The findings include:  The facility's nursing services failed to ensure that Client #1's laboratory assessments were scheduled monthly as recommended by the nephrologist.  On January 17, 2012, at 9:07 a.m., Client #1 was observed to be significantly overweight for her height. Interview with the medication nurse at 9:13 a.m., revealed the client had gained a lot of weight during the last year, however, the cause had not been determined. Interview with the qualified intellectual disabilities professional (QIDP) at 9:58 a.m., revealed that numerous studies had been performed to monitor the client's condition and to address her weight gain.  On January 18, 2012, at 2:32 p.m., review of a nephrology consultation dated February 3, 2011	W 331		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 11</p> <p>revealed that Client #1 was being monitored by the nephrologist for her diagnosis of nephrogenic diabetes insipidus. The consultation report revealed that the client was evaluated for weight gain, shortness of breath, nephrogenic diabetes insipidus, and hypothyroidism. The nephrologist recommended to decrease the client's fluid intake to 3 liters per day, and to monitor sodium twice weekly, then monthly. Review of the followup nephrology consultation dated July 7, 2011, revealed to continue to monitor the client's labs monthly. Record review revealed no monthly lab values were available for the months of April, May, July, September, and October 2011, to confirm that the client's sodium had been monitored monthly as recommended.</p> <p>Interview with the director of nursing (DON) on January 19, 2012, at 3:30 p.m., revealed that the primary care physician approved the nephrologist's recommendations for Client #1 and that they were being implemented. The DON indicated that all medical appointments are scheduled by the nurse at the administrative office. Further discussion with the DON revealed that she would follow-up with the primary care physician (PCP) and the nurses at the administrative office to determine if lab results were available for the aforementioned months. On January 20, 2012, at 11:30 a.m., the DON acknowledged that her discussion with the PCP and the nurses revealed no additional lab reports were available for the client. At the time of the survey, there was no evidence that Client #1 received the lab tests during the months of April, May, July, September, and October 2011, as recommended.</p>	W 331	<ol style="list-style-type: none"> <li>The EEG attempted 8-23-11, was intended to be a sleeping EEG. Client #2 was sedated but did not go to sleep. However, the sedation improved her level of cooperativeness and the EEG was completed successfully (See: the attached note from the PCP)...2-20-12</li> <li>There was a change in the RN supports and the new RN did not pick up this mandate. The erstwhile RN ensured that the requirement was added to the physician's orders but not to the Health Management Care Plan for better tracking and follow up by the RN. The issue has been added to the HMCP at this time. The January and February 2012 sodium level checks have been within normal limits...2-20-12</li> </ol> <p>The QIDP will review the HMCP mandates monthly as a cross check audit to ensure ongoing compliance on all requirements...3-1-12</p> <p>W331</p>		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW	W 365			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 365	<p>Continued From page 12</p> <p>An individual medication administration record must be maintained for each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the medication administration record (MAR) was timely documented for one of three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure Client #1's medication administration record (MAR) was maintained, as evidenced below:</p> <p>Observation of the medication administration on January 17, 2012, beginning at 9:10 a.m., revealed the licensed practical nurse (LPN) administered Client #1 Chlorpromazine HCl, 100 mg tablet, Clonazepam 2 mg tablet, Levothyroxine Sodium 25 mcg tablet, Multi-Delyn S/F liquid, 5 ml, and Nexium UD 40 mg capsule SA by mouth. Further observation revealed that after the administration of the medications, the nurse failed to update the client's MAR. At approximately 9:35 a.m., the LPN was observed to exit the home.</p> <p>Interview with the aforementioned medication nurse on January 18, 2011, at 8:37 a.m., indicated that all medications administered should be signed by the licensed personnel who administers them. Further discussion with the LPN revealed that her failure to document the medication administration record for Client #1</p>	W 365			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 56TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 365	Continued From page 13 was an oversight. The LPN also stated that she returned to the facility during the evening on January 17, 2012 to document the administration of the previously identified medications.	W 365	There was a change in the RN supports and the new RN did not pick up this mandate. The erstwhile RN ensured that the requirement was added to the physician's orders but not to the Health Management Care Plan for better tracking and follow up by the RN. The issue has been added to the HMCP at this time. The January and February 2012 sodium level checks have been within normal limits...2-20-12		
W 368	483.460(k)(1) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on staff observation, interview and record review, the facility failed to implement its system that ensured all drugs were administered in compliance with the physician's orders for two of five clients in the facility. (Clients #1 and #5)  The findings include:  1. The facility failed to ensure that Client #1 received Levothyroxine Sodium 25 mcg tablet on an empty stomach as prescribed.  On January 17, 2012, at 8:22 a.m., direct care staff revealed that Client #1 had already eaten her breakfast. At 9:17 a.m., the LPN, was observed to administer the client's Levothyroxine Sodium 25 mcg tablet. Interview with the LPN during this time revealed the client received the	W 368	W365		

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 368	Continued From page 14 medication as a thyroid supplement.  Interview with the director of nursing on January 20, 2012, at 11:20 a.m., revealed the system required an investigation to ensure that Client #1 was administered the Levothyroxine Sodium 25 mcg tablet on an empty stomach.  2. The facility failed to ensure that Client #5 received the prescribed dosage of Enulose 10 mg/15 ml solution, 30 ml.  On January 17, 2011, at 9:04 a.m., the licensed practical nurse (LPN) was observed to administer Client #5 Enulose (10 mg/15ml solution), 15 ml. Observation of the medication bottle revealed that it was empty.  At 9:06 a.m., the LPN commented that the client should have received Enulose 10 mg/15ml solution, 30 ml, however, the pharmacy had not delivered the monthly supply of the medication. Interview with the director of nursing on January 17, 2012, at 10:42 a.m., revealed that a supply of medication should be maintained for the client.  On January 18, 2012, at 3:39 p.m., review of the facility's policy on ordering of medications revealed the nurse will assure all necessary medications are available and well maintained for use by the residents. The policy further revealed to ensure the residents always have at least a 30 day supply of medication when ordering.  The facility failed to implement its system to ensure the administration of Enulose in compliance with the physician's order.	W 368	The DON will re-train the medication nurse in question on ensuring that medication passes are properly documented at the time of the medication pass...2-28-12 Medication administration documentation will be reviewed at minimum weekly by the RN with appropriate follow up of any issues found...2-28-12  W368		
W 369	483.460(k)(2) DRUG ADMINISTRATION	W 369			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 65TH STREET, NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 15  The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all drugs were administered without error, for two of five clients residing in the facility (Clients #1 and #5).  The findings include:  1. [Cross refer to W368.1. ]. The facility failed to ensure that Client #1 was administered Levothyroxine Sodium 25 mcg tablet on an empty stomach as prescribed.  2. [Cross refer to W368.2 ]. The facility failed to ensure that Client #5 was administered the prescribed amount of Enulose 10 mg/15ml solution.	W 369	2. The DON will re-train the medication nurses to ensure they report medication supply needs in a timely manner...2028-12 The assigned RN and/or the Administrative Support LPNs will review medication supplies bimonthly to ensure that all medications are maintained in adequate supply...3-1-12  W369	
W 474	483.480(b)(2)(iii) MEAL SERVICES  Food must be served in a form consistent with the developmental level of the client.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received their meals in the form and consistency as prescribed, for one of the three clients in the sample. (Client #2)  The finding includes:	W 474		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	<p>Continued From page 16</p> <p>Observation on January 17, 2012, at 6:57 p.m., revealed the direct support staff served Client #2 pureed shrimp, potatoes, carrots, string beans and noodles. The spinach was served in a regular consistency.</p> <p>Interview with the direct support staff at approximately 7:00 p.m., revealed Client #2 was on a pureed diet. When asked, the staff stated the spinach was pureed.</p> <p>Review of Client #2's physician's order dated December 1, 2011, on January 18, 2012, at 9:00 a.m., revealed the client was prescribed a pureed low cholesterol diet.</p> <p>The facility failed to ensure Client #2 received her food in the texture prescribed to meet her developmental needs.</p>	W 474	<ol style="list-style-type: none"> <li>The medication nurse had been arriving close to the end of the two-hour medication window and as a result, causing breakfast for Client #1 to be later and later. The nurse's route plan has been changed to ensure that she arrives significantly earlier (45 to 60 minutes) so as not to compromise breakfast. The QJDP will train the staff to hold breakfast without fail until the nurse arrives to pass medications for Client #1 (i.e. her breakfast)...2-28-12 The RN will track arrival times by the medication nurse to ensure breakfast is not unreasonably delayed...2-28-12</li> <li>The DON will re-train the medication nurses to ensure they report medication supply needs in a timely manner...2028-12 The assigned RN and/or the Administrative Support LPNs will review medication supplies bimonthly to ensure that all medications are maintained in adequate supply...3-1-12</li> </ol> <p>W474</p>	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 000	INITIAL COMMENTS  A licensure survey was conducted from January 17, 2012 through January 20, 2012. A sample of three residents was selected from a population of five women with varying degrees of intellectual disabilities.  The findings of the survey were based on observations in the home and at two day programs, interview with one client's guardian, staff at the home and at the two day programs, as well as a review of client and administrative records, including incident reports.  [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1 000		
1 042	3502.2(b) MEAL SERVICE / DINING AREAS  Modified diets shall be as follows:  (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...  This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disability (GHPID) failed to ensure that modified diets were served as prescribed, for one of the three residents included in the sample. (Resident #2)  The finding includes:  Observation on January 17, 2012, at 6:57 p.m., revealed the direct support staff served Resident #2 pureed shrimp, potatoes, carrots, string beans	1 042	3502.2  The QIDP and Facility Manager conducted training on ensuring that each food item is properly pureed for Client #2 and the proper use of the equipment...1-20-12 This training was reinforced in the February 3, 2012 staff meeting...2-3-12 The QIDP will set up a formal training session by the nutritionist...3-10-12 The facility manager will observe food texture during meal observations conducted at minimum 3 times weekly...3-1-12	

Health Regulation & Licensing Administration

*Patricia M. Moore* Director of Residential Services  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE DATE 2/2/12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0236</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1042	Continued From page 1  and noodles. The spinach was served in a regular consistency.  Interview with the direct support staff at approximately 7:00 p.m., revealed Resident #2 was on a pureed diet. When asked, the staff stated the spinach was pureed.  Review of Resident #2's physician's order dated December 1, 2011, on January 18, 2012, at 9:00 a.m., revealed the resident was prescribed a pureed low cholesterol diet.  The facility failed to ensure Resident #2 received her food in the texture prescribed to meet her developmental needs.	1042		
1090	<b>3504.1 HOUSEKEEPING</b>  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.  This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner.  The findings include:  Observations during the environmental walk-through and interview with the residential director, (RD), on January 17, 2012, beginning at approximately 11:30 a.m., revealed the following:	1090	<b>3504.1</b>  1. The hole will be filled by 2-26-12 as a temporary solution. The hole will be addressed permanently in the spring so that the final work is not compromised by winter weather...4-1-12 2. The gutter will be cleaned by...2-26-12  The facility manager will conduct bimonthly environmental audits and report issues found to the program assistant for follow up. The program assistant's duties have been changed to place more emphasis on environmental upkeep...3-1-12	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 090	Continued From page 2  1. There was a hole in the ground, on the right side of the paved walkway leading to the steps of the front entrance to the facility. Closer observation of the hole revealed that the hole extended underneath the walkway, which present a potential living environment for pests.  2. The gutter installed above the front porch had leaves in it.  Interview with the RD during the environmental walk-through acknowledged the above identified findings.	1 090		
1 229	3510.5(f) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to ensure that each staff was effectively trained to meet the needs of one of three residents in the sample. (Resident #1)  The findings include:  The GHPID failed to ensure that each staff received ongoing training on Resident #1's intake and output documentation, as evidenced below:  On January 19, 2012, at 3:37 p.m., review of Resident #1's intake and output records for October, November and December 2011	1 229	3510.5 (f)  The Facility Manager will review the data for Client #1's intake and output at minimum 5 days weekly and the QIDP will review the data at minimum 3 times weekly. Issues discovered will be addressed with staff either on the spot or on their next scheduled shift...3-1-12 The QIDP and Facility Manager conducted a training session before the end of the survey addressing this concern...1-20-12 The issue was also addressed in the February 2012 all staff meeting...2-3-12	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 3  revealed five of thirteen weekly intake and output forms reviewed were not dated.  Interview with the qualified intellectual disabilities professional (QIDP) and the residential director (RD) on January 20, 2012, at 11:02 a.m., acknowledged the finding and confirmed that the date of all intake and output should be recorded for Resident #1. They also revealed that all direct care staff had been trained on the resident's health management care plan, which included how to document the resident's fluid intake and output. The RD indicated that she is required to monitor the information staff documents on the intake and output forms daily. The QIDP stated that she coordinates with the RD, and may monitor the intake and output forms if the RD is not on duty.  On January 19, 2012, 3:53 p.m., record review revealed staff training on Resident #1's health management care plan, which included interventions on how to monitor the resident's intake and out put protocol.  At the time of the survey, there was no evidence the training provided was adequate to ensure that staff documented the required information at all times.	I 229		
I 379	3519.10 EMERGENCIES  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be	I 379	3519.10  *The Director of Residential Services will meet with the QIDP to reinforce the importance of submitting incident reports within 24 hours, including situations where the status of an incident changes. Reporting of incidents is systematically tracked for ongoing compliance and issues are reviewed with the QIDP during monthly meetings with the Director...3-1-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1379	<p>Continued From page 4</p> <p>followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that injuries of unknown origin were reported immediately to the State Survey Agency (SSA) timely, for one of the three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on January 17, 2012, at 10:30 a.m., revealed that on January 3, 2012, Resident #1 was seen in the emergency room for a swollen hand. The emergency room report revealed that the client's finger was fractured.</p> <p>An interview was conducted with the qualified intellectual disabilities professional (QIDP) on January 20, 2012, at 10:30 a.m., to ascertain information regarding the facility's incident management system. According to the QIDP, all incidents of unknown origin should be reported immediately to the State agency. Review of the incident report, however, revealed that the state agency was notified two days after the incident was reported.</p>	1379			
1401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment</p>	1401			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1401	<p>Continued From page 5</p> <p>services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included treatment services, and services designed to prevent deterioration or further loss of functioning by the resident for two of three residents in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. The GHPID failed to ensure Resident #2 received timely follow-up to address her frequent syncope episodes.</p> <p>a. On January 17, 2012, beginning at 10:00 a.m., review of Resident #2's incident reports revealed she was unresponsive and taken to the emergency room (ER) six times, between May 15, 2011, and November 24, 2011. Three of the six ER visits resulted in hospital admissions for further evaluation. Record review on January 18, 2012, beginning at 10:00 a.m., revealed that during the aforementioned ER visits/hospitalizations, the resident was recommended to be evaluated by cardiology and neurology. Continued record review revealed the following information regarding the specialty visits.</p> <p>On January 19, 2012, at 3:00 p.m., record review revealed Resident #2 was hospitalized from November 23, 2011 through November 25, 2011 for altered mental status. Review of a primary care physician (PCP) progress note dated</p>	1401	<p>3520.3</p> <ol style="list-style-type: none"> <li>The EEG attempted 8-23-11, was intended to be a sleeping EEG. Client #2 was sedated but did not go to sleep. However, the sedation improved her level of cooperativeness and the EEG was completed successfully (See: the attached note from the PCP)...2-20-12</li> <li>There was a change in the RN supports and the new RN did not pick up this mandate. The erstwhile RN ensured that the requirement was added to the physician's orders but not to the Health Management Care Plan for better tracking and follow up by the RN. The issue has been added to the HMCP at this time. The January and February 2012 sodium level checks have been within normal limits...2-20-12</li> </ol> <p>The QIDP will review the HMCP mandates monthly as a cross check audit to ensure ongoing compliance on all requirements...3-1-12</p> <ol style="list-style-type: none"> <li>The QIDP will contact the psychologist and set up the needed BSP training by...3-15-12 The QIDP will ensure that all training needs are tracked, scheduled and implemented in a timely manner and will report any support needs to the Director of Residential...3-1-12 Training needs will be reviewed with the Director in monthly meetings with the QIDP...3-1-12</li> </ol>	
------	--	------	---	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0236</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>MULTI-THERAPEUTIC SERVICES, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>927 55TH STREET, NE WASHINGTON, DC 20019</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1401	<p>Continued From page 6</p> <p>November 29, 2011, following the hospitalization, revealed the resident was evaluated and continued neurology follow-up was recommended for syncope</p> <p>Interview with the residential director (RD) and the registered nurse (RN) on January 19, 2012, at 3:00 p.m., revealed Resident #2's follow-up neurology appointment was scheduled for December 29, 2011; however, the neurology office called to reschedule the appointment for January 2012. The RD indicated that the appointment time offered conflicted with the time residents are transported from their day programs. Therefore, a new appointment was obtained for the next available appointment date, March 5, 2012 (three months later).</p> <p>At the time of the survey, the GHPID failed to ensure the resident's neurology follow-up was conducted timely as recommended.</p> <p>b. A post ER PCP medical progress note dated June 30, 2011, revealed Resident #1 was evaluated at the ER for altered mental status. The PCP recommended follow-up by the cardiologist and neurologist. The resident returned to the ER on July 14, 2011 and was admitted for syncope. Review of the discharge summary dated July 18, 2011, revealed an EEG was performed and it was unclear what the results showed. The neurological consultation report dated July 28, 2011, revealed the resident was evaluated for episodes of loss of consciousness and possible dystonia. The report further revealed that medication could be prescribed to treat the dystonia; however, a sleeping EEG must first be conducted. In the consultation report dated, July 28, 2012, the neurologist also referenced the EEG conducted at the hospital on July 14, 2011,</p>	1401		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 7  stating that it concluded there was significant motion artifact. The report further revealed that the resident "may eventually need another EEG study under sedation." A consultation report dated August 23, 2011, confirmed that a sleeping EEG was attempted. The impression revealed it was probably within normal limits, however, a sleep EEG may be useful in clarifying the study further.  Interview with the qualified intellectual disabilities professional (QIDP) and the nurse on January 19, 2012, at 3:02 p.m. revealed that the sleeping EEG recommended on August 23, 2011, had not been addressed by the PCP for Resident #2.  2. The GHPID failed to ensure that Resident #1's serum sodium level was monitored monthly as recommended.  On January 17, 2012, at 9:07 a.m., Resident #1 was observed to be significantly overweight for her height. Interview with the medication nurse at 9:13 a.m., revealed the resident had gained a lot of weight during the last year, however, the cause had not been determined. Interview with the QIDP at 9:58 a.m., revealed that numerous studies had been performed to monitor the resident's condition and to address her weight gain.  On January 18, 2012, at 2:32 p.m., review of a nephrology consultation dated February 3, 2011 revealed that Resident #1 was being monitored by the nephrologist for her diagnosis of nephrogenic diabetes insipidus. The consultation report revealed that the resident was evaluated for weight gain, shortness of breath, nephrogenic diabetes insipidus, and hypothyroidism. The nephrologist recommended to decrease the	I 401		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	<p>Continued From page 8</p> <p>resident's fluid intake to 3 liters per day, and to monitor sodium twice weekly, then monthly. Review of the followup nephrology consultation report dated July 7, 2011, revealed to continue to monitor the resident's labs monthly. Record review revealed no monthly lab values were available for the months of April, May, July, September, and October 2011, to confirm that the resident's sodium had been monitored monthly as recommended.</p> <p>Interview with the director of nursing (DON) on January 19, 2012, at 3:30 p.m., revealed that the primary care physician approved the nephrologist's recommendations for Resident #1, and that they were being implemented. Further discussion with the DON revealed that she would follow-up with the primary care physician (PCP) and the nurses at the administrative office to determine if lab results were available for the aforementioned months. On January 20, 2012, at 11:30 a.m., the DON acknowledged that her discussion with the PCP and the nurses revealed no additional lab reports were available for the resident. At the time of the survey, there was no evidence that Resident #1 received the lab tests during the months of April, May, July, September, and October 2011, as recommended.</p> <p>3 The GHPID failed to ensure training was provided by the psychologist to facilitate the timely implementation of Resident #1's revised behavior support plan (BSP).</p> <p>Observation of the medication administration on January 17, 2012, beginning at 9:10 a.m., revealed the licensed practical nurse (LPN) administered Resident#1 Chlorpromazine HCl, 100 mg tablet and Clonazepam 2 mg tablet. Interview with the nurse during the medication</p>	I 401		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1401	Continued From page 9  administration revealed these medications were prescribed for maladaptive behaviors. During the evening observations on January 17, 2012, staff was observed redirecting the resident when she hit the wall with her hand.  Review of the medication administration record (MAR) on January 17, 2012, at 9:47 a.m., revealed Resident#2 was also prescribed Paxil 40 mg in the evening for behavior. It should be noted that on January 12, 2012, the previous order of Paxil 20 mg was increased due an increase in the resident's targeted behavior of aggression.  Interview with the qualified intellectual disabilities professional (QIDP) on January 17, 2012, at 10:37 a.m., revealed that due to a significant increase in Resident#1's behavior, Paxil 20 mg prescribed in the evening for behavior, was recently increased to Paxil 40 mg. The QIDP also revealed that the resident's revised BSP dated December 10, 2011, was approved by the human rights committee (HRC) on November 22, 2011. The revised BSP was to be implemented after staff received training from the psychologist. The QIDP indicated, however, that the revised BSP had not been implemented because she had not been able to confirm a date with the psychologist for the training.  On January 18, 2011, at 1:42 p.m., HRC minutes dated November 22, 2011 revealed the review and approval of of Resident#1's revised BSP dated December 10, 2011. The resident's previous BSP dated December 10, 2010, which continued to be implemented, instructed the staff to record target behaviors (explosive episodes) that last for 5 minutes or more, and the resident cannot be easily redirected. The revised BSP	1401		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 10  dated December 10, 2011, instructed the staff to record target behaviors only when they last 20 minutes or more, and the resident cannot be redirected easily. At the time of the survey, there was no evidence staff was provided training by the psychologist to facilitate the implementation of the revised BSP.	I 401		
I 405	<b>3520.7 PROFESSION SERVICES: GENERAL PROVISIONS</b>  Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners.  This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents included in the sample. (Resident #2)  The finding includes:  On January 18, 2012, beginning at 11:48 a.m., Resident #2 was observed drooling as the day program staff assisted her with a recognition assignment. At 11:49 a.m., the day program staff handed Resident #2 a paper towel and asked her to wipe her mouth. The resident did not respond therefore the direct support staff wiped her mouth with hand over hand assistance. Continued observation revealed the direct support staff then placed the paper towel on the table.	I 405	3520.7  The QJDP will meet with the day program to discuss this training concern. The QJDP will ensure that the staff is retrained on proper infection control practices with emphasis on managing the drooling tendency of Client #2. Training will be documented and MTS will maintain copies...3-2-12  Additionally the QJDP and facility manager will visit the program at minimum monthly and will observe for ongoing compliance. Issues seen will be reported to the day program management staff...3-1-12	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/20/2012
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 827 55TH STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1405	Continued From page 11  Interview with the day program case manager on January 18, 2012, at approximately 12:30 p.m., revealed the day program staff was required to put the paper towel in the trash after the resident's mouth was wiped.  At the time of the survey the day program staff failed to implement infection control procedures.	1405		