

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR 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 3/23/2010, through 3/25/2010. The survey was completed utilizing the fundamental survey process. A random sampling of four clients was selected from a residential population of seven females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at four day programs, as well as a review of the client and administrative records, including the incident reports.	W 000	<p style="text-align: center;"><i>Revised 4/16/10</i></p> <p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, O.C. 20002</p>	
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure outside services met the needs of one of the four sampled clients. (Client #3)</p> <p>The findings include:</p> <ul style="list-style-type: none"> The facility failed to ensure that Client #3's day program provided her diet as prescribed as evidenced below: <p>Observation at Client #3's day program (DP) on 3/25/2010, at approximately 11:30 a.m., revealed she received a meal of peas and rice with cabbage stew. The other two clients sitting at the table with her also was served a meal of peas and rice with cabbage stew and two pieces of baked chicken.</p>	W 120	<p>The QMRP will consult with the day program, nursing team, and nutritionist of Client #3 in order to develop a meal protocol and establish the likes and dislikes of Client #3. In the future, the QMRP will communicate with the day programs of all individuals to ensure that their diets are consistent and appropriate.</p>	5/07/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Constantine A. Reese* TITLE: *Program Director* DATE: *4/16/10*

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: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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	<p>Continued From page 1</p> <p>Interview with the attending staff at the day program on the same day and time revealed, Client #3 did not receive any meat with her meal (baked chicken) because she dislikes eating meat. The day program staff further added, "It's been well over a year since Client #3 has received any meat with her meals".</p> <p>In addition, it was made clear by the staff that in the past, she would not eat all of her food if meat was served with her meal. Since they stopped offering meat, she has been eating 100% of her food.</p> <p>Information gathered through interview with the QMRP on 3/25/2010, at approximately 1:45 p.m., however, revealed she was not aware Client #3 was not being provided any meat to eat at her day program.</p> <p>Review of Client #3's physician's orders on 3/25/2010, at 2:15 p.m., revealed she was prescribed a "Regular - Double portions" diet. Additional record review on 3/25/2010, at 2:45 p.m. revealed, Client #3's quarterly nutritional assessment dated 2/2/2010, documented that she lost six (6) pounds over the past three months. According to the nutritional assessment, Client #3's weight of 115 pounds at the time of the assessment, was below her ideal body weight range of 117 - 130 pounds.</p> <p>At the time of the survey, there was no evidence that the day program had communicated Client #3's mealtime food preferences to the group home to ensure that she received a nutritionally balanced diet as prescribed.</p>	W 120			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159			

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 159	<p>Continued From page 2</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for one of the four residents in the sample. (Resident #3)</p> <p>The findings include:</p> <p>The facility's QMRP failed to coordinate and monitor services at Client #3's day program, to ensure she received a nutritionally balanced diet. [See W120]</p>	W 159	<p>Cross reference W120</p>	5/07/10
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to address the health care needs of three of the seven clients residing in the facility. (Clients #1, #3 and #5)</p> <p>The findings include:</p> <p>1. The facility failed to ensure staff was adequately trained to implement the calorie restricted diets for Clients #1 and #5, as</p>	W 192	<p>1. The QMRP will consult with the nutritionist in order to implement a snack menu for all individuals. The staff will be trained on the snack protocol for all individuals.</p>	5/07/10

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 192	<p>Continued From page 3 evidenced below:</p> <p>On 3/23/2010, at 7:45 a.m., Clients #1 and #5 both appeared to be above their ideal body weight range. On 3/23/2010, at 2:47 p.m., they were observed seated at the dining table eating a snack, which consisted of approximately 1/2 cup of walnuts and a large cup of water. On 3/24/2010, at 6:15 p.m., the clients were observed being served graham crackers after dinner. The attending staff indicated the graham crackers were being served as their dessert.</p> <p>Interview with the staff on 3/23/2010, at 6:30 p.m., revealed both clients were currently prescribed 1500 calorie weight loss diets. Interview with the qualified mental professional (QMRP) on 3/25/2010, at 1:45 p.m., revealed all of the clients were allowed to have a snack when they returned to the group home from the day program, if they so desired. Further interview with the QMRP revealed snack type foods were always available. The QMRP stated, however, that the menus did not document a specific food to be served as an afternoon snack. It was also confirmed during interview that the dinner dessert appeared on the menus as the night time snack.</p> <p>The review of the fall and winter cycle menus on 3/24/2010, at 2:17 p.m. revealed the dinner dessert was scheduled to be served as a night time (p.m.) snack. The menu review also confirmed that no afternoon snacks were listed.</p> <p>Subsequent review of training records on 3/24/2010, at 2:40 p.m., revealed no training was documented on the provision of between meal snacks.</p>	W 192			

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
--	---

(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 192	<p>Continued From page 4</p> <p>At the time of the survey, there was no evidence staff had been trained on allowable afternoon snacks for calorie restricted diet to ensure the calories consumed did not exceed the calories prescribed.</p> <p>2. The facility failed to ensure staff was trained on the provision of nutritionally balanced between meal snacks for Client #3, as evidenced below:</p> <p>On 3/23/2010, at approximately 4:00 p.m., Client # 3 was observed removing a jar of jelly and mayonnaise from the refrigerator, while being supervised by a staff. Approximately 5 minutes later, the client was observed seated at the table eating a jelly/mayonnaise sandwich and drinking a glass of juice. The client consumed 100% of the sandwich.</p> <p>Interview with the staff on 3/23/2010 at approximately 4:15 p.m. revealed Client #3 was offered a choice of snacks, however, the jelly and mayonnaise sandwich was one of her favorites. Interview with the QMRP on 3/25/2010 at approximately 3:55 p.m. revealed that no menu substitution list was available for Client #3.</p> <p>Review of Client #3's physician's orders on 3/25/2010, at 2:15 p.m. revealed she was prescribed a "Regular - Double portions" diet. Additional record review on 3/25/2010 at 2:45 p.m., however revealed, Client #3's quarterly nutritional assessment dated 2/2/2010 documented that she lost six (6) pounds over the past three months. According to the nutritional assessment, Client #3 weight of 115 pounds at the time of the assessment, was below her ideal body weight range of 117 - 130 pounds.</p>	W 192	<p>2. Cross reference W192 #1</p>	5/07/10
-------	--	-------	-----------------------------------	---------

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
--	---

(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 192 Continued From page 5
At the time of the survey, there was no evidence that staff had been provided effective training on the management of between meal snacks for the Client #3, to ensure her nutritional needs were met.

W 192

W 229 483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN

W 229

The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.

Cross reference W232

5/19/10

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure objectives documented in the Individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome for one of the four clients included in the sample. (Client #4)

The finding includes:

Interview with the day program staff on 3/24/2010, at approximately 11:25 a.m., and also with the group home QMRP on the same day at 2:40 p.m. revealed Client #4 had a goal designed to increase her community living skills, which required her to identify and count money.

Record review on 3/24/2010, at approximately 11:30 a.m., at the day program and later at 2:45 p.m. at the residential facility revealed, Client #4 had an objective to "independently identify US Coins, and put coin combinations together to make a purchase on 2/2 trials on 17/20 days per month." At the time of the survey, there was no evidence that the objective had been stated in a manner to obtain a single outcome. [See W232]

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 232	<p>483.440(c)(4)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>The objectives of the individual program plan must be organized to reflect a developmental progression appropriate to the individual.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the individual program plan was organized to reflect the developmental level of one of four clients in the sample.(Client #4]</p> <p>The finding includes:</p> <p>Observation on 3/24/2010, at approximately 11:15 a.m., at Client #4 ' s day program revealed she was being quizzed by the attending staff on identifying her home address. The staff also asked Client #4 to recite what she should do when faced with an emergency. Client #4 was not able to accurately answer either of the two questions.</p> <p>Interview with the day program staff on 3/24/2010, at approximately 11:35 a.m., revealed Client #4 was not able to identify numbers or letters. The staff further impored that it would be best to have Client #4 learn her letters and numbers first before attempting to get her to learn any of the skills identified above. In addition, the day program staff indicated it would be beneficial if the home assisted the day program in teaching Client #4 her numbers and letters before implementing any of the programs.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 3/25/3010, at approximately 3:20 p.m., confirmed Client #4 was</p>	W 232	<p>The QMRP will implement IPP goals that require Client #4 to be trained on learning how to recognize letters and numbers. The QMRP will train the staff on the new IPP goals.</p>	5/18/10	

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 232	<p>Continued From page 7</p> <p>not capable of identifying numbers, letters, or able to recite her home address. Further interview with the QMRP on the same day and time revealed it would be best for Client #4 to master her basic skills of identifying numbers and letters before implementing her current programs.</p> <p>Record review on 3/24/2010, at approximately 11:30 a.m., at the day program and later at 2:45 p.m. at the residential facility revealed, Client #4 was assigned the following programmatic goals and objectives:</p> <p>1. Community Living Skills Objective #1: "[Client #4] will locate the numbers and letters on the bingo board given 1 verbal cue on 1/2 trials on 17/20 days per month."</p> <p>2. Community Survival Skills: Objective #2: "[Client #4] will recite personal information upon request given 1 verbal cue on 3/4 trials on 17/20 days per month."</p> <p>3. Community Survival Skills Objective #3: "[Client #4] will independently identify US Coins and put coin combinations together to make a purchase on 2/2 trials on 17/20 days per month."</p> <p>4. Community Survival Objective #4: "[Client #4] will say "Dial 911" when asked what she should do in case of an emergency given one verbal cue on 1/2 trials on 17/20 days per month."</p> <p>Review of Client #4's Psychological assessment dated 8/7/2009 on the same day and time</p>	W 232		
-------	--	-------	--	--

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
--	---

(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 232	Continued From page 8 revealed, she functioned at "the severe range of cognitive impairment"	W 232		
W 356	<p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health of one of four clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Interview with the qualified mental retardation professional (QMRP) on 3/24/2010, at approximately 1:35 p.m., revealed recent dental interventions had been initiated for Client #2, beginning on 11/09/2009. The QMRP revealed that client was due to receive recommended periodontal treatment services. Continued interview with the QMRP revealed the client's dental health and the treatment recommendations had been discussed with the client's medical guardian. The QMRP also indicated the client was currently waiting for a review of the full mouth x-rays by the periodontist, so that the most</p>	W 356	<div style="border: 1px solid black; padding: 5px;"> <p>In the future, the facility will ensure that all clients receive the the recommended evaluations and treatments. The QMRP and the primary nurse will review all medical records and follow-up on a regular basis. Appointments will be made at Howard University Hospital for Client #2's required dental treatments. The periodontist who recommended general anesthesia was not able to do general anesthesia in his office.</p> </div>	5/19/10

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

PRINTED: 04/08/2010
FDM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011	
(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 356	<p>Continued From page 9</p> <p>effective and least invasive treatment regimen for the client could be implemented.</p> <p>Record review on 3/24/2010, at approximately 1:45 p.m., revealed the client had not been received ongoing monitoring and treatment services for the maintenance of her dental health as evidenced below:</p> <p>a. 2/13/2008 - Patient presented for continued treatment. However, upon re-evaluation ... it has been determined that [Client] should be evaluated by a periodontist. Please contact a periodontist. If the teeth cannot be saved, we will fabricate the dentures and extract the remaining teeth."</p> <p>b. 11/9/2009 - "Emergency oral examination. Patient complains about a loose tooth (#10). Tooth is mobile. X-ray taken and revealed that the tooth has severe bone loss (approximately 75%) that causes mobility. Dx: Advanced Periodontal Disease, generally. Recommendation Patient should be seen by a Periodontist to determine if her teeth can be saved for an extended period. This office can perform maintenance therapy to try to retain her teeth as long as possible. Unless she exhibits some pain, as infection, please try to contact, the Periodontist. Her next appointment at this office will be for an exam and cleaning.</p> <p>c. 12/10/2009 - Annual oral examination and cleaning. Consultation report documented "No clinical signs of pathology. Gums are pink and no bleeding observed. Anterior teeth are mobile (7-11) and lower incisors. This patient has advanced gum disease which should be treated by a periodontist. Gum specialist to evaluate her long term prognosis. In the Interim, she will be seen at this office for maintenance, therapy only</p>	W 356		

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
--	---

(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 356	<p>Continued From page 10 (cleaning). A periodontist can be located by calling the Medicaid office or the DC Dental Society. A return appointment was given for 4/8/2010."</p> <p>d. 12/24/2009 - Consultation report documented "Periodontal examination and charting was done. Waiting for her full mouth x-ray for diagnosis and treatment plan".</p> <p>e. 1/21/2010 - Client presented for full mouth x-ray recommended by the periodontist. "Patient does not follow command and the x-ray is not the best...Could not take a full mouth series...Enclosed is the Panorex x-ray".</p> <p>f. 2/12/2010 - Periodontal consultation: Diagnosis/finding - Advanced periodontist. Full mouth scaling, root planing, and full mouth periodontal surgery may be required. Some teeth are hopeless. Sedation or general anesthesia required.</p> <p>On 3/24/2010, at approximately 2:10 p.m., review of a nursing note dated 2/12/2010, revealed the periodontal clinic reported that it would only performed dental surgery under local anesthesia, which may not be feasible for Client #2.</p> <p>Record review on 3/24/2010, at approximately 2:20 p.m., confirmed that Client #2 had a return appointment scheduled with the periodontist for 4/8/2010.</p> <p>At the time of the survey, there was no evidence Client #2 had been provided timely dental follow-up assessment and treatment services to address the concerns identified in the 2/2008.</p>	W 356		
W 460	483.480(a)(1) FOOD AND NUTRITION	W 460	Cross reference W120	5/07/10

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

PRINTED: 04/08/2010
FDRM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 460	<p>Continued From page 11 SERVICES</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one of four clients in the sample received a well balanced diet. (Client #3)</p> <p>The finding includes: [Cross Reference W120]</p> <p>The facility failed to ensure that Client #3 was provided a double portion diet as prescribed as evidenced below:</p> <p>1. Observation at Client #3's day program (DP) on 3/25/2010, at approximately 11:30 a.m., revealed she received a meal of peas and rice with cabbage stew. The other two clients sitting at the table with her also was served a meal of peas and rice with cabbage stew and two pieces of baked chicken.</p> <p>Interview with the attending staff at the day program on the same day and time revealed, Client #3 did not receive any meat with her meal (baked chicken) because she dislikes eating meat. The day program staff further added, "It's been well over a year since Client #3 has received any meat with her meals".</p> <p>There was no evidence on file at the time of survey to reflect the facility was aware of Client</p>	W 460		
-------	---	-------	--	--

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
--	---

(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 460	<p>Continued From page 12</p> <p>#3's refusal to eat meat. Additionally, there was no evidence no evidence that food substitute had been identified to ensure that the client received a nutritionally balanced diet.</p> <p>2. Observation on 3/23/2010 at approximately 4:00 p.m., Client #3 was observed eating a jelly/mayonnaise sandwich.</p> <p>Further observation on the same day and time at 5:35 p.m. revealed, Client #3 received a bowl of beef stew containing of chunks of carrots and other vegetables at dinner. Client #3 refused her serving of beef stew and was provided a toasted bagel with jelly to eat as a substitute for her meal.</p> <p>Interview with staff on 3/23/2010, at approximately 5:45 p.m., revealed the bagel and jelly sandwich was provided to Client #3 because it was what the client "wanted to eat instead of her beef stew". Interview with the facility's qualified mental retardation professional (QMRP) on 3/25/2010 at approximately 3:55 p.m. verified there was no menu substitution list established for Client #3.</p> <p>Review of Client #3's physician's order sheets dated 3/1/2010 on 3/25/2010 at 2:15 p.m. revealed she was prescribed a "Regular - Double portions" diet on 7/11/1994.</p> <p>Additional record review on 3/25/2010, at 2:45 p.m. revealed, Client #3's quarterly nutritional assessment dated 2/2/2010, documented that she lost six (6) pounds over the past three months. At the date of the nutritional assessment, Client #3 weighed 115 pounds and was below her ideal body weight range of 117 - 130 pounds.</p>	W 460		
-------	--	-------	--	--

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

PRINTED: 04/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
--	---

(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 480	<p>Continued From page 13</p> <p>At the time of the survey, there was no evidence the facility had provided effective monitoring of Client #3's nutritional regimen to address her refusal of meals, and to ensure the provision of a nutritionally balanced double portion regular diet, which contained sufficient calories to maintain the client's body weight within the established ideal range.</p>	W 480		
-------	--	-------	--	--

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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
--------------------	--	---------------	---	--------------------

1000	INITIAL COMMENTS A re-licensure survey was conducted from 3/23/2010, through 3/25/2010. A random sampling of four residents was selected from a residential population of seven females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at four day program, as well as a review of the resident and administrative records, including the incident reports.	1000		
1075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that each bedroom was equipped with a night stand for each resident for five of seven residents. (Residents #3, #4, #5, #6 and #7) The finding includes: During the inspection of the environment on 3/24/2010, beginning at approximately 9:30 a.m., the bedrooms of Residents #3, #4 #5, #6 and #7 were observed to have no nightstands for the individuals. During the interview on 3/24/2010, at approximately 9:40 a.m., the qualified mental retardation professional (QMRP) acknowledged that the nightstands had not been provided for the	1075	Nightstands will be purchased for Residents #3, #4, #5, #6, and #7.	5/19/10

Health Regulation Administration
Christine A. Reese
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 TITLE *Program Director*
 (X6) DATE *4/16/10*
 STATE FORM 6899 KWZ711 If continuation sheet 1 of 15

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WIND _____	(X3) DATE SURVEY COMPLETED 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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
--------------------	--	---------------	---	--------------------

1075	Continued From page 1 residents' bedrooms. At the time of the survey, there was no evidence that each bedroom had been equipped with the minimum required items, as required by District of Columbia Municipal Regulations.	1075										
1090	3504.1 HOUSEKEEPING 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 the Mentally Retarded Persons (GHMRP) failed to ansure the interior and exterior of the GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner for seven of the seven residents in the facility. (Residents #1, #2, #3, #4, #5, #6, and #7) The findings include: During the inspection of the environment on 3/24/2010, beginning at approximately 9:30 a.m., the following concerns were identified: A. Exterior: 1. Cracks were observed in the walkway leading from the front of the facility. 2. Rust had accumulated on the furniture located on the front porch. 3. Cracks were observed in the ceiling of the front	1090	<table border="1"> <tr> <td data-bbox="852 1669 1339 1711">Exterior</td> <td data-bbox="1339 1669 1485 1711"></td> </tr> <tr> <td data-bbox="852 1711 1339 1753">1. Cracks in the walkway in front of the facility will be repaired.</td> <td data-bbox="1339 1711 1485 1753">3/30/10</td> </tr> <tr> <td data-bbox="852 1753 1339 1795">2. Porch furniture will be removed of rust and repainted.</td> <td data-bbox="1339 1753 1485 1795">5/19/10</td> </tr> <tr> <td data-bbox="852 1795 1339 1879">3. Cracks in the ceiling in the front porch will be repaired.</td> <td data-bbox="1339 1795 1485 1879">05/19/10</td> </tr> </table>	Exterior		1. Cracks in the walkway in front of the facility will be repaired.	3/30/10	2. Porch furniture will be removed of rust and repainted.	5/19/10	3. Cracks in the ceiling in the front porch will be repaired.	05/19/10	
Exterior												
1. Cracks in the walkway in front of the facility will be repaired.	3/30/10											
2. Porch furniture will be removed of rust and repainted.	5/19/10											
3. Cracks in the ceiling in the front porch will be repaired.	05/19/10											

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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
1090	Continued From page 2 porch. B. Interior: 1. First Floor a. Kitchen - There was an accumulation of brown baked grease on a glass baking dish. b. Dining room - The door of the closet located in the corner of the room, would not properly close. 2. Basement a. Stains were observed on the carpet. Threads were raveling from the carpet. 3. Second Floor: a. Bathroom (1) Water stained tiles were observed on the ceiling, above the tub. (2) There was a hole in the wall above the sink. 4. Third Floor: a. Bathroom - Tiles were missing from the wall. b. Bedrooms - Soiled areas were observed on the carpet on the floor of the bedroom of Residents #3, and #4. The aforementioned observations were acknowledged by the QMRP, who accompanied the surveyor during the inspection of the environment.	1090	Interior 1 (a.) A new glass baking dish will be purchased. (b.) The closet door in the dining room will be repaired closely. 2 a. Carpet in basement will be removed and floor will be tiled. 3. (1). Water stained tiles on the ceiling above the tub in the 2nd floor bathroom will be replaced. (2). The wall will be repaired above the sink in the 2nd floor bathroom. 4 (a.) Missing tile from the wall in the 3rd floor bathroom will be replaced. (b.) Carpet will be removed from the bedrooms of Resident #3 and #4 on the 3rd floor.	5/19/10 5/19/10 5/19/10 5/19/10 5/19/10 5/19/10
1180	3508.1 ADMINISTRATIVE SUPPORT	1180		

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 180	<p>Continued From page 3</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for two of the four residents in the sample. (Resident #3 and #4)</p> <p>The findings include:</p> <p>1. The facility's QMRP failed to coordinate and monitor services at Resident #3's day program, to ensure she received a nutritionally balanced diet as evidenced below:</p> <p>Observation at Resident #3's day program (DP) on 3/25/2010, at approximately 11:30 a.m., revealed she received a meal of peas and rice with cabbage stew. The other two residents sitting at the table with her also was served a meal of peas and rice with cabbage stew and two pieces of baked chicken.</p> <p>Interview with the attending staff at the day program on the same day and time revealed, Resident #3 did not receive any meat with her meal (baked chicken) because she dislikes eating meat. The day program staff further added, "It's been well over a year since Resident #3 has received any meat with her meals".</p> <p>In addition, it was made clear by the staff that in the past, she would not eat all of her food if meat was served with her meal. Since they stopped offering meat, she has been eating 100% of her</p>	I 180	<p>1. Cross reference W120</p>	5/07/10

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 180	Continued From page 4 food. Information gathered through interview with the QMRP on 3/25/2010, at approximately 1:45 p.m., however, revealed she was not aware Resident #3 was not being provided any meat to eat at her day program. Review of Resident #3's physician's orders on 3/25/2010, at 2:15 p.m., revealed she was prescribed a "Regular - Double portions" diet. Additional record review on 3/25/2010, at 2:45 p.m. revealed, Resident #3's quarterly nutritional assessment dated 2/2/2010, documented that she lost six (6) pounds over the past three months. According to the nutritional assessment, Resident #3's weight of 115 pounds at the time of the assessment, was below her ideal body weight range of 117 - 130 pounds. At the time of the survey, there was no evidence that the day program had communicated Resident #3's mealtime food preferences to the group home to ensure that she received a nutritionally balanced diet as prescribed. 2. The facility's QMRP failed to ensure the individual program plan was organized to reflect the developmental level of one of four residents in the sample.(Resident #4) as evidenced below: Observation on 3/24/2010, at approximately 11:15 a.m., at Resident #4 's day program revealed she was being quizzed by the attending staff on identifying her home address. The staff also asked Resident #4 to recite what she should do when faced with an emergency. Resident #4 was not able to accurately answer either of the two questions.	I 180	2. Cross reference W229	5/19/10

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 180	Continued From page 5 Interview with the day program staff on 3/24/2010, at approximately 11:35 a.m., revealed Resident #4 was not able to identify numbers or letters. The staff further implored that it would be best to have Resident #4 learn her letters and numbers first before attempting to get her to learn any of the skills identified above. In addition, the day program staff indicated it would be beneficial if the home assisted the day program in teaching Resident #4 her numbers and letters before implementing any of the programs. Interview with the facility's qualified mental retardation professional (QMRP) on 3/25/2010, at approximately 3:20 p.m., confirmed Resident #4 was not capable of identifying numbers, letters, or able to recite her home address. Further interview with the QMRP on the same day and time revealed it would be best for Resident #4 to master her basic skills of identifying numbers and letters before implementing her current programs. Record review on 3/24/2010, at approximately 11:30 a.m., at the day program and later at 2:45 p.m. at the residential facility revealed, Resident #4 was assigned the following programmatic goals and objectives: a. Community Living Skills Objective #1: "[Resident #4] will locate the numbers and letters on the bingo board given 1 verbal cue on 1/2 trials on 17/20 days per month." b. Community Survival Skills: Objective #2: "[Resident #4] will recite personal information upon request given 1 verbal cue on 3/4 trials on 17/20 days per month."	I 180		

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 180	<p>Continued From page 6</p> <p>c. Community Survival Skills Objective #3: "[Resident #4] will independently identify US Coins and put coin combinations together to make a purchase on 2/2 trials on 17/20 days per month."</p> <p>d. Community Survival Objective #4: "[Resident #4] will say "Dial 911" when asked what she should do in case of an emergency given one verbal cue on 1/2 trials on 17/20 days per month."</p> <p>Review of Resident #4's Psychological assessment dated 8/7/2009 on the same day and time revealed, she functioned at "the severe range of cognitive impairment"</p> <p>At the time of the survey, there was no evidence that the facility ensured Resident #4 was able to recognize numbers and alphabets prior to implementing the current community living/community survival training objectives.</p> <p>3. The facility's QMRP failed to ensure objectives documented in the individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome for one of the four residents included in the sample, (Resident #4) as evidenced below:</p> <p>Interview with the day program staff on 3/24/2010, at approximately 11:25 a.m., and also with the group home QMRP on the same day at 2:40 p.m. revealed Resident #4 had a goal designed to increase her community living skills, which required her to identify and count money.</p> <p>Record review on 3/24/2010, at approximately</p>	I 180	<p>3. Cross reference W232</p>	5/19/10
-------	---	-------	--------------------------------	---------

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 180	Continued From page 7 11:30 a.m., at the day program and later at 2:45 p.m. at the residential facility revealed, Resident #4 had an objective to "independently identify US Coins, and put coin combinations together to make a purchase on 2/2 trials on 17/20 days per month." At the time of the survey, there was no evidence that the objective had been stated in a manner to obtain a single outcome.	I 180		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure that all staff were effectively trained to address the nutritional needs of three of the seven residents residing in the GHMRP. (Residents #1, #3 and #5) The findings include: 1. The GHMRP failed to ensure staff was adequately trained to implement the calorie restricted diets for Residents #1 and #5, as evidenced below: On 3/23/2010, at 7:45 a.m., Residents #1 and #5 both appeared to be above their ideal body weight range. On 3/23/2010, at 2:47 p.m., they were observed seated at the dining table eating a snack, which consisted of approximately 1/2 cup of walnuts and a large cup of water. On 3/24/2010, at 6:15 p.m., the residents were observed being served graham crackers after dinner. The attending staff indicated the graham crackers were being served as their dessert. Interview with the staff on 3/23/2010, at 6:30	I 222	1. Cross reference W480	5/07/10

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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
--------------------	--	---------------	---	--------------------

1222 Continued From page 8

p.m., revealed both residents were currently prescribed 1600 calorie weight loss diets. Interview with the qualified mental professional (QMRP) on 3/25/2010, at 1:45 p.m., revealed all of the residents were allowed to have a snack when they returned to the group home from the day program, if they so desired. Further interview with the QMRP revealed snack type foods were always available. The QMRP stated, however, that the menus did not document a specific food to be served as an afternoon snack. It was also confirmed during interview that the dinner dessert appeared on the menus as the night time snack.

The review of the fall and winter cycle menus on 3/24/2010, at 2:17 p.m. revealed the dinner dessert was scheduled to be served as a night time (p.m.) snack. The menu review also confirmed that no afternoon snacks were listed.

Subsequent review of training records on 3/24/2010, at 2:40 p.m., revealed no training was documented on the provision of between meal snacks.

At the time of the survey, there was no evidence staff had been trained on allowable afternoon snacks for calorie restricted diet to ensure the calories consumed did not exceed the calories prescribed.

2. The GHMRP failed to ensure staff was trained on the provision of nutritionally balanced between meal snacks for Resident #3, as evidenced below:

On 3/23/2010, at approximately 4:00 p.m., Resident # 3 was observed removing a jar of jelly and mayonnaise from the refrigerator, while being supervised by a staff. Approximately 5 minutes

1222

2. Cross reference W192

5/07/10

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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
--------------------	--	---------------	---	--------------------

1222 Continued From page 9

later, the resident was observed seated at the table eating a jelly/mayonnaise sandwich and drinking a glass of juice. The resident consumed 100% of the sandwich.

Interview with the staff on 3/23/2010 at approximately 4:15 p.m. revealed Resident #3 was offered a choice of snacks, however, the jelly and mayonnaise sandwich was one of her favorites. Interview with the QMRP on 3/25/2010 at approximately 3:55 p.m. revealed that no menu substitution list was available for Resident #3.

Review of Resident #3's physician's orders on 3/25/2010, at 2:15 p.m. revealed she was prescribed a "Regular - Double portions" diet. Additional record review on 3/25/2010 at 2:45 p.m., however revealed, Resident #3's quarterly nutritional assessment dated 2/2/2010 documented that she lost six (6) pounds over the past three months. According to the nutritional assessment, Resident #3 weight of 115 pounds at the time of the assessment, was below her ideal body weight range of 117 - 130 pounds.

At the time of the survey, there was no evidence that staff had been provided effective training on the management of between meal snacks for the Resident #3, to ensure her nutritional needs were met.

1222

1401 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS

Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

1401

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 10</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services for two of the four residents in the sample. (Residents #2 and #3)</p> <p>The findings includes:</p> <p>1. The GHMRP failed to ensure timely treatment services for the maintenance of dental health for Resident #2 as evidence below:</p> <p>Interview with the qualified mental retardation professional (QMRP) on 3/24/2010, at approximately 1:35 p.m., revealed recent dental interventions had been initiated for Resident #2, beginning on 11/092009. The QMRP revealed that resident was due to receive recommended periodontal treatment services. Continued interview with the QMRP revealed the resident's dental health and the treatment recommendations had been discussed with the resident's medical guardian. The QMRP also indicated the resident was currently waiting for a review of the full mouth x-rays by the periodontist, so that the most effective and least invasive treatment regimen for the resident could be implemented.</p> <p>Record review on 3/24/2010, at approximately 1:45 p.m., revealed the resident had not been received ongoing monitoring and treatment services for the maintenance of her dental health as evidenced below:</p> <p>a. 2/13/2008 - Patient presented for continued treatment. However, upon re-evaluation ... It has been determined that [Resident] should be evaluated by a periodontist. Please contact a</p>	I 401	<p>1. Cross reference W356</p>	5/19/10
-------	--	-------	--------------------------------	---------

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 11</p> <p>periodontist. If the teeth cannot be saved, we will fabricate the dentures and extract the remaining teeth."</p> <p>b. 11/9/2009 - "Emergency oral examination. Patient complains about a loose tooth (#10). Tooth is mobile. X-ray taken and revealed that the tooth has severe bone loss (approximately 75%) that causes mobility. Dx: Advanced Periodontal Disease, generally. Recommendation Patient should be seen by a Periodontist to determine if her teeth can be saved for an extended period. This office can perform maintenance therapy to try to retain her teeth as long as possible. Unless she exhibits some pain, as infection, please try to contact, the Periodontist. Her next appointment at this office will be for an exam and cleaning.</p> <p>c. 12/10/2009 - Annual oral examination and cleaning. Consultation report documented "No clinical signs of pathology. Gums are pink and no bleeding observed. Anterior teeth are mobile (7-11) and lower incisors. This patient has advanced gum disease which should be treated by a periodontist. Gum specialist to evaluate her long term prognosis. In the interim, she will be seen at this office for maintenance, therapy only (cleaning). A periodontist can be located by calling the Medicaid office or the DC Dental Society. A return appointment was given for 4/6/2010."</p> <p>d. 12/24/2009 - Consultation report documented "Periodontal examination and charting was done. Waiting for her full mouth x-ray for diagnosis and treatment plan".</p> <p>e. 1/21/2010 - Resident presented for full mouth x-ray recommended by the periodontist. "Patient</p>	I 401		
-------	---	-------	--	--

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 12</p> <p>does not follow command and the x-ray is not the best...Could not take a full mouth series...Enclosed is the Panorex x-ray".</p> <p>f. 2/12/2010 - Periodontal consultation: Diagnosis/finding - Advanced periodontist. Full mouth scaling, root planing, and full mouth periodontal surgery may be required. Some teeth are hopeless. Sedation or general anesthesia required.</p> <p>On 3/24/2010, at approximately 2:10 p.m., review of a nursing note dated 2/12/2010, revealed the periodontal clinic reported that it would only performed dental surgery under local anesthesia, which may not be feasible for Resident #2.</p> <p>Record review on 3/24/2010, at approximately 2:20 p.m., confirmed that Resident #2 had a return appointment scheduled with the periodontist for 4/6/2010.</p> <p>At the time of the survey, there was no evidence Resident #2 had been provided timely dental follow-up assessment and treatment services to address the concerns identified in the 2/2008.</p> <p>2. The GHMRP failed to ensure that Resident #3 received a double portion, well balanced diet as evidenced below:</p> <p>a. Observation at Resident #3's day program (DP) on 3/25/2010, at approximately 11:30 a.m., revealed she received a meal of peas and rice with cabbage stew. The other two residents sitting at the table with her also was served a meal of peas and rice with cabbage stew and two pieces of baked chicken.</p> <p>Interview with the attending staff at the day</p>	1401	<p>2. Cross reference W120</p>	5/07/10
------	--	------	--------------------------------	---------

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011
---	---

(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 13</p> <p>program on the same day and time revealed, Resident #3 did not receive any meat with her meal (baked chicken) because she dislikes eating meat. The day program staff further added, "It's been well over a year since Resident #3 has received any meat with her meals".</p> <p>There was no evidence on file at the time of survey to reflect the GHMRP was aware of Resident #3's refusal to eat meat. Additionally, there was no evidence no evidence that food substitute had been identified to ensure that the resident received a nutritionally balanced diet.</p> <p>b. Observation on 3/23/2010 at approximately 4:00 p.m., Resident #3 was observed eating a jelly/mayonnaise sandwich.</p> <p>Further observation on the same day and time at 5:35 p.m. revealed, Resident #3 received a bowl of beef stew containing of chunks of carrots and other vegetables at dinner. Resident #3 refused her serving of beef stew and was provided a toasted bagel with jelly to eat as a substitute for her meal.</p> <p>Interview with staff on 3/23/2010, at approximately 5:45 p.m., revealed the bagel and jelly sandwich was provided to Resident #3 because it was what the resident "wanted to eat instead of her beef stew ". Interview with the GHMRP's qualified mental reterdation professional (QMRP) on 3/25/2010 at approximately 3:55 p.m. verified there was no menu substitution list established for Resident #3.</p> <p>Review of Resident #3's physician's order sheets dated 3/1/2010 on 3/25/2010 at 2:15 p.m. revealed she was prescribed a "Regular - Double portions" diet on 7/11/1994.</p>	I 401		

PRINTED: 04/08/2010
FORM APPROVED

Health Regulation 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 03/25/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 703 RANDOLPH STREET NW WASHINGTON, DC 20011		
(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 14 Additional record review on 3/25/2010, at 2:45 p.m. revealed, Resident #3's quarterly nutritional assessment dated 2/2/2010, documented that she lost six (6) pounds over the past three months. At the date of the nutritional assessment, Resident #3 weighed 115 pounds and was below her ideal body weight range of 117 - 130 pounds. At the time of the survey, there was no evidence the GHMRP had provided effective monitoring of Resident #3's nutritional regimen to address her refusal of meals, and to ensure the provision of a nutritionally balanced double portion regular diet, which contained sufficient calories to maintain the resident's body weight within the established ideal range.	I 401		