

PRINTED: 04/28/2011
FORM APPROVED
OMB NO. 0938-0391

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/25/2011 |
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| NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 000 | <p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from March 23, 2011 through March 25, 2011. A sample of three clients was selected from a population of one man and four women with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process.</p> <p>The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.</p> | W 000 | <p><i>Received 5/9/11</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.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 that clients' day programs implemented clients' mealtime protocols, to include prescribed adaptive eating equipment, for one of the three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>1. On March 23, 2011, at 6:49 a.m., a direct support staff was observed feeding Client #1 his breakfast. The warm foods (cream of wheat and boiled egg) had been pureed and were served in a divided plate. Later that day, at 12:05 p.m., a day program direct support staff was observed</p> | W 120 | | |

LABORATORY BY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kretz Moore* TITLE *Exec. Dir* (X6) DATE *5/9/11*

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

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| W 120 | <p>Continued From page 1</p> <p>opening an aluminum tray (divided) of warm foods. The lunch consisted of pureed turkey, macaroni and cheese, and sweet potatoes. The staff removed the food items from the aluminum tray and placed them into a scoop plate that was not divided. The pureed foods were observed spreading across the bottom of the plate, mixing into one another. The client's first name was observed written in black magic marker on the side of the scoop plate being used.</p> <p>On March 23, 2011, beginning at 3:15 p.m., review of Client #1's Individual Support Plan (ISP), dated July 22, 2010, revealed that he was prescribed a "sectional, divided plate."</p> <p>On March 25, 2011, at approximately 10:15 a.m., the qualified intellectual disabilities professional (QIDP) was asked about Client #1's meals at the day program. She stated that she had observed him receiving lunch approximately two months prior to the survey. She also confirmed that he was prescribed a divided plate. When asked about the white scoop plate with his name on it, the QIDP recalled having seen the scoop plate being used.</p> <p>2. Cross-refer to W194. Observation of Client #1's lunch served at the day program revealed that the staff failed to implement instructions as prescribed in his Mealtime Protocol (MP). The MP, dated July 2010, included the following: "Encourage <client's name> to eat without physical support of staff. If he will not eat after 3-5 minutes of encouragement, provide hand over hand support with facing to promote independence." Staff was observed, however, providing hand over hand support immediately</p> | W 120 | <p>W120</p> <p>The QIDP will meet with the day program staff of Client #1 to insure that the program has the prescribed sectional plate and to insure that it is used consistently. Additionally, the QIDP will reinforce the importance of encouraging Client #1 to eat with as little staff support as possible. The QIDP will document the follow up in the monthly notes... 5-22-11</p> <p>The QIDP provided the day program with a new plate.... 5-2-11</p> <p>The QIDP and other support staff will monitor compliance during routine visits to the program (minimum monthly). Failure to use the prescribed sectional plate or provide support during the meal as per the prescribed protocol will be reported to the management levels of the day program for follow up... 5-22-11</p> <p>The QIDP and other members of the residential management team will visit the day program of each individual supported in the home to insure that no other such deficient practices exist. If any are uncovered, the QIDP will inform the management staff of the program and plan follow up in coordinated fashion... 6-1-11</p> <p>The above-mentioned process will be conducted on a minimum a monthly basis. The QIDP will document the visit findings in the monthly notes... 6-1-11</p> | | |

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W 120 Continue From page 2
from the start of the meal, without first providing encouragement.

W 194 483.430(c)(4) STAFF TRAINING PROGRAM

Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

This STANDARD is not met as evidenced by:
Based on observations, interviews and record verification, the facility failed to ensure staff demonstrate competency in implementing clients' mealtime protocols, for one of the three clients in the sample. (Client #1)

The findings include:

Client #1 was observed at breakfast on March 23, 2011, beginning at 6:50 a.m. After presenting the client's plate, a direct support staff informed him what he was about to eat. At 6:52, the staff placed a specialized, angled spoon into the client's right hand, held the client's hand with his own and began feeding him with hand over hand support. The client, however, was resistive and food spilled onto his chin and bib. The staff asked him "you want me to feed you?" After a 10-second pause, the staff answered for him "yeah." After another 10-second pause, the staff said "let's try one more time." He resumed hand over hand assistance and the client again refused to cooperate. By 6:54 a.m., the staff was spoon feeding the client his breakfast. Staff spoon fed him throughout the rest of his meal.

W 120

W 194

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W 194

Continued From page 3

Client #1 was observed at his day program on March 23, 2011. At 12:05 p.m., a day program staff opened an aluminum tray of warm foods (pureed turkey, macaroni and cheese, and sweet potatoes). He transferred the foods into a scoop plate and placed a specialized, angled spoon on the side of the plate. At approximately 12:07 p.m., another day program staff placed the spoon into the client's right hand, held the client's hand using both of her hands and began feeding him. Even though Client #1 resisted her hand over hand support she persisted and he participated to that extent (hand over hand) throughout the remainder of his meal. Staff at the day program were observed referring to a Mealtime Protocol (MP), dated July 2010, which resembled the same one that had been observed in the kitchen earlier that day in the home.

Client #1 was observed receiving snack in his home later that afternoon, at 4:28 p.m. After offering him a choice of snack items, a direct support staff was observed using the same technique used by the day program staff at lunch (using both hands to provide hand over hand support while feeding the client a serving of yogurt).

1. On March 24, 2011, at 9:37 a.m., review of Client #1's MP, dated July 2010, revealed the following instructions: "Encourage <client's name> to eat without physical support of staff. If he will not eat after 3-5 minutes of encouragement, provide hand over hand support with facing to promote independence." The three different staff observed in the home and at day program were all observed to give the client hand over hand support immediately, without first

W 194

W194

1. The QIDP provided additional training for the home staff to reinforce the importance of following the meal protocol for Client #1... 3-24-11

The QIDP will monitor meals at minimum once weekly for all shifts to insure that the meal protocol is consistently followed. The facility manager will observe meals for all shifts at minimum twice weekly (separate from the QIDP observations) to insure routine compliance. Any failures to follow the protocols during observations will result in appropriate follow up action (on-the-spot training, counseling, disciplinary follow up, etc.)... 5-22-11

The QIDP will schedule a formal training by the OT to reinforce the proper use of the sectional plate and implementation of the meal protocol... 5-30-11

The QIDP and facility manager will monitor the implementation of active treatment as implemented on all shifts on a routine weekly basis at minimum (separately) to insure that all protocols and programs are implemented consistently as prescribed... 6-1-11

2. See: W120 response

3. See: #1 above

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| W 194 | <p>Continued From page 4</p> <p>offering him encouragement to feed himself (for a period of 15 minutes), in accordance with the MP.</p> <p>2. During the day program visit, at 12:24 p.m., interview with the direct support staff assisting Client #1 at lunch revealed that she had been employed there "for a year." When asked if she had received training on his MP, she replied "yeah, I can hand over hand with him." Interview with the qualified intellectual disabilities professional (QIDP) on March 25, 2011, beginning at 6:50 a.m., revealed that she had observed a lunch at day program approximately two months prior to the survey. When asked at 10:39 a.m., if staff at the day program had received training on Client #1's MP, the QIDP stated that an LPN had provided training in the past "but not his one," referring to the July 2010 revision. There was no evidence that staff at Client #'s day program had received effective training on implementing his MP.</p> <p>3. In-service training records for residential staff were reviewed on March 24, 2011, beginning at 2:51 p.m. The facility had documented an October 12, 2010 training by the Occupational Therapist regarding clients' mealtime protocols. Review of the staff signature sheets revealed that nine (9) staff including the man observed assisting Client #1 at breakfast (6:50 a.m.) on the day before had been in attendance. There was no signature however, of the staff that was observed assisting the client with his yogurt at 4:28 p.m. There was no evidence that staff in Client #1's home had received effective training on implementing his MP.</p> | W 194 | | |
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| W 194 | Continued From page 5 This is a repeat deficiency. | W 194 | | |
| W 227 | <p>In a deficiency report dated December 18, 2009, the facility was cited for staff failure to implement another client's realtime protocol.</p> <p>483.440(c)(1) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop training programs to address assessed needs, for one of the three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>Client #1 wore a bib during his breakfast on March 23, 2011, beginning at 6:50 a.m. There was spillage of food and drool onto the bib. A direct support staff used a napkin to wipe his mouth throughout the meal. Similar observations were made later that day, at 12:17 p.m., while a direct support staff fed him lunch at the day program. The only difference noted was that staff in the home spoon fed the client, whereas the staff at day program provided hand over hand support throughout the meal.</p> <p>1. On March 23, 2011, beginning at 3:15 p.m.,</p> | W 227 | | |

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(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
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03/25/2011

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(X5)
COMPLETION
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W 227

Continued From page 6
review of Client #1's record revealed an Individual Support Plan (ISP), dated July 22, 2010. The ISP included an interdisciplinary team (IDT) recommendation for the following training goal: "<client's name> will feed himself and eat at least 50% of his food with the appropriate device." Staff in the home and at day program was identified as responsible for implementation. At 3:43 p.m., review of monthly reports prepared by the qualified intellectual disabilities professional (QIDP) showed no evidence that the facility had developed and implemented a training program in accordance with the IDT's recommendation.

Interview with the QIDP on March 25, 2011, beginning at 9:50 a.m., confirmed that Client #1 did not have a training program for feeding himself. She indicated that the client previously had a training program. This, however, could not be verified through further record review. The QIDP stated that the IDT had adopted the client's Mealtime Protocol, updated July 2010 by the Occupational Therapist (OT), and incorporated it in the ISP.

2. On March 23, 2011, beginning at 3:15 p.m., review of Client #1's ISP, dated July 22, 2010 revealed an IDT recommendation for the following training goal: "<client's name> will obtain independence skills by completing a household chore. <Client's name> will wipe the table after meals." The client had not been observed wiping the table after breakfast in the home or after lunch at the day program earlier that day. At 3:43 p.m., review of monthly reports prepared by the QIDP showed no evidence that the facility had developed and implemented a training program in accordance with the IDT's

W 227

W227

The two goals for feeding himself and wiping the table have been developed along with data collection systems for each and staff instructions. Staff has been trained on implementation and implementation has begun...3-25-11

It should be noted that these two objectives have been run in the past and it had been determined that Client #1 had reached his maximum potential in these areas. The QIDP asked the DDS Service Coordinator to exclude them from the most recent ISP but they got included. The QIDP did not catch that in her edit review. The goals will be run again for the remainder of this ISP year (i.e. through June 2011). It will be determined thereafter, based on his progress or lack thereof, whether either should be continued into the new ISP year...7/11

The Director of Residential Programs will review all components of the ISP developed by the QIDP to insure that they are complete and accurate. The Assistant to the Director will review finalized ISPs as a second cross check to the QIDP review to insure that the document is accurate and complete. MTS management staff will provide ISP edits to the Service Coordinator when issues are found in the review process...6-1-11

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W 227 Continued From page 7
recommendation.

W 227

Interview with the QIDP on March 25, 2011, beginning at 9:50 a.m., confirmed that Client #1 did not have a training program for wiping the table. At 10:25 a.m., the QIDP stated the client could "benefit from such a goal."

W 242 483.440(c)(6)(ii) INDIVIDUAL PROGRAM PLAN

W 242

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene dental hygiene, self-feeding, bathing, dressing grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

This STANARC is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to document the provision of training in personal skills essential for independence (specifically, using a napkin) until it was demonstrated that the client was incapable of acquiring the skills, for one of the three clients in the sample. (Client #1)

The finding includes:

Client #1 wore a bib during his breakfast on March 23, 2011, beginning at 6:50 a.m. There was spillage of food and he drooled onto the bib. A direct support staff used a napkin to wipe his mouth throughout the meal. Similar observations were made later that day, at 12:17 p.m., while a

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| W 242 | <p>Continued From page 8</p> <p>direct support staff fed him lunch at the day program. Staff in both setting were observed with a Mealtime Protocol, dated July 2010, and signed by an Occupational Therapist.</p> <p>On March 21, 2011, at 1:29 p.m., review of Client #1's Occupational Therapy (OT) assessment, dated June 3, 2010, revealed that the client did not use a napkin independently. There was no evidence that the client had a training program for a napkin mouth wiping program.</p> <p>When interviewed on March 25, 2011, beginning at 9:50 a.m., the QIDP confirmed that Client #1 did not have a training program for wiping his mouth with a napkin. She stated that he had received training on using a napkin in the past, "probably the year before last." This, however, could not be verified through further record review. The QIDP stated that the IDT had adopted the client's Mealtime Protocol, updated July 2010 by the Occupational Therapist, and incorporated it in the ISP. She acknowledged that the Mealtime Protocol did not reflect whether or not staff were to provide assistance with wiping his mouth.</p> | W 242 | | |
| W 249 | <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> | W 249 | | |

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| W 249 | <p>Continued From page 9</p> <p>This STATEM is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received continuous active treatment, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>During snack observations on March 23, 2011, at 4:15 p.m. the direct care staff offered Client #3 a variety of snacks. After she completed her snack, staff presented a communication device. The device had pictures of a person eating, waving hello and good-bye, and strolling in a wheelchair. Once a picture was pushed the word was said. Staff was observed pushing the picture of a person eating, to which one could hear a recorded message "I am hungry." Interview with the direct care staff, at 4:50 p.m., revealed that the client used the device to express her wants.</p> <p>On March 25, 2011, beginning at 9:25 a.m., review of Client #3's IPP dated May 24, 2010, revealed a program objective which stated, "[the client] will be able to use a voice output/picture communication symbols in order to express some of her fundamental needs, wants and desires given gestural cues on 3 out of 4 trials."</p> <p>On March 24, 2011, at 11:55 a.m., review of Client #3's speech assessment, dated July 23, 2010, revealed that she had severe speech and language deficits. The assessment recommended that the client receive exposure to cause and effect activities to increase her overall responsiveness.</p> | W 249 | <p>W249</p> <p>The QIDP re-trained staff on the proper use of Client #3's communications device...4-15-11 The QIDP will schedule a formal, follow up training session by the speech pathologist. This training will occur by...5-30-11 The Speech Pathologist will be asked to develop a formal protocol for staff to follow in supporting Client #3 in the use of the communications device...5-30-11 The QIDP will observe the implementation of this program during routine monthly active treatment observations and will provide on-the-spot training to staff if any is observed failing to properly support Client #3 in using the communications device to express her needs...5-15-11 The QIDP will review the status of all needed adaptive equipment for each person supported to insure that each individual supported has all needs met and that the equipment is used as prescribed...6-1-11 The QIDP will coordinate follow up on any issues found and will document both the findings and the follow up activities...6-1-11 Reviews will occur at minimum on a routine monthly basis...6-1-11</p> | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICAL & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G183 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/25/2011 |
| NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4614-16 JAY 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 249 | Continued From page 10 | W 249 | | |
| W 322 | <p>Interview with the qualified intellectual disabilities professional on March 25, 2011, at approximately 12:15 a.m., revealed that the client should use her communication device to express her wants, needs and/or desires prior to the selection presented to her. The staff, however, failed to implement Client #3's communication goal as written, on the previous evening. They did not present the voice output/picture communication board to Client #3 prior to (or during) snack time.</p> <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, staff interview and record review, the facility's primary care physician (PCP) failed to ensure general and preventative care services for one of the three clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>The facility failed to ensure timely medical follow-up for Client #2, as evidenced by the following:</p> <p>Observation of the evening medication administration on March 23, 2011, beginning at 7:31 a.m., revealed Client #2 received Ferrous Sulfate and a Colgard tablet. Interview with the medication nurse during the medication administration revealed that the medications</p> | W 322 | | |

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|---|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4814-18 JAY 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 11</p> <p>were used for treatment of her diagnoses of anemia and osteopenia, respectively.</p> <p>1. On March 23, 2011, beginning at 2:10 p.m., review of Client #2's medical record revealed a hematologist consult dated November 23, 2010. The hematologist recommended laboratory studies (B-2 levels, serum ferritin, T3, T4, TSH, and a peripheral blood smear) and return in four months. Further record review, however, revealed no evidence that she had returned to the hematologist or had received the laboratory studies, as recommended.</p> <p>On March 23, 2011, at approximately 3:20 p.m., the registered nurse (RN) acknowledged that Client #2 had not returned to the hematologist since November 23, 2010 nor had the laboratory studies been scheduled. On March 24, 2011, at approximately 11:00 a.m., the director of nursing stated that the appointments would be scheduled.</p> <p>2. On March 23, 2011, beginning at 2:10 p.m., review of Client #2's medical record revealed that a Dexacen scan was attempted on January 4, 2011. The consult sheet indicated that the client was uncooperative due to her inability to remain still during scan; therefore, the scan was not completed. There was no documented evidence that the PCP had been made aware that the client did not have the scan and no new order was reflected.</p> <p>On March 23, 2011, at approximately 3:30 p.m., the RN acknowledged that Client #2 did not have a follow-up Dexacen scan consult nor had one been scheduled. On March 24, 2011, at</p> | W 322 | <p>W322</p> <p>1. The needed serum lab work was completed on...3-29-11 All of the levels checked were normal with the exception of B12 but the PCP does not believe that to be significant...4-1-11 Client #2 was seen by hematology on...4-5-11 Normal exam results with a recommendation to follow up in six months</p> <p>2. Client #2 had the Dexacen scan completed on...4-7-11 No changes were suggested in her treatment regimen. The PCP has reviewed the results.</p> <p>The DON will meet with the Assigned RN to insure that the MTS Medical Appointment Tracking form is used proactively on an ongoing basis to track, schedule and implement the needed medical follow up for each person supported...6-1-11 The RN will be required to submit the completed, updated forms for each person supported for review by the DON during monthly Nursing meetings. The QIDP will review the medical records monthly to insure needed follow up is implemented and documented in a timely manner. The QIDP will report issues found to the assigned RN and DON as needed...6-1-11 The assigned RN, QIDP and facility manager meet monthly to review the status of medical follow up and to proactively plan upcoming follow up...6-1-11</p> | |

...to continued program participation.

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G183

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

03/25/2011

NAME OF PROVIDER OR SUPPLIER

MULTI-THERAPEUTIC SERVICES, INC

STREET ADDRESS, CITY, STATE, ZIP CODE

441416 JAY 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

Continued from page 12
approximately 11:00 a.m., the director of nursing
stated that an appointment would be scheduled.
483.460(g) 2) COMPREHENSIVE DENTAL
TREATMENT

W 322

W 356

The facility must ensure comprehensive dental
treatment services that include dental care
needed for relief of pain and infections,
restoration of health, and maintenance of dental
health.

W 356

This STA IDAID is not met as evidenced by:
Based on interview and record review, the facility
failed to ensure preventive care to ensure the
maintenance of clients' dental health, for one of
the three clients in the sample. (Client #1)

The finding includes:

Client #1's dental records were reviewed on
March 21, 2011, beginning at 12:15 p.m.
According to a consultation report dated June 30,
2010, the dentist recommended extraction of
teeth #23, #24, #25 and #26. On October 20,
2010, Client #1's sister signed a written consent
form for dental extractions, and the record
showed that his teeth #23, #24 and #25 were
extracted the same day. The client's dental
records showed that he was seen again by the
dentist on November 9, 2010 and December 22,
2010. There was no evidence that the status of
tooth #26 had been addressed. At 12:28 p.m.,
review of Client #1's Monthly Nurse Notes for the
period June 2010 - March 2011 revealed no
indication that the facility's nursing staff had
sought to determine whether tooth #26 had been

The extractions were done by a back up dentist because the
primary dentist was on vacation on the scheduled date.
Client #1 is scheduled to return to the dentist
on... June 28, 2011.
The issue will be addressed at that time. MTS will insure
that dental is provided with the previous order for the
extraction of #26 and all needed information on the consult
form and attachments...6-28-11.

The assigned RN will track dental follow up as assisted by
the QDIP to insure that all required follow up is completed
as prescribed and in a timely manner. Dental issues will be
addressed during the RN/QDIP/Facility Manager monthly
meetings and appropriate follow up steps will be planned
and where possible implemented at that time...6-1-11
Problems with obtaining Prior Authorizations in a timely
manner will be reported to the DDS Service Coordinator
for assistance and other elements of the DDS support
system if it becomes necessary. Follow up will be
documented in the routine monthly notes of the QIDP and
RN...6-1-11

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| NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019 | |
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| W 356 | Continued From page 13 extracted as originally recommended on June 30, 2010. The qualified intellectual disabilities professional (QIDP) was interviewed on March 25, 2011, at 11:12 a.m. She stated that she could only speculate as to whether or not the dentist had changed her recommendation to extract tooth #26. She acknowledged that to date, the facility had not inquired about the tooth. The QIDP further stated that she would ensure that tooth #26 was re-assessed when Client #1 returned to the dentist on June 28, 2011. | W 356 | | |
| W 381 | 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure all medications were properly secured, for one of the five clients residing in the facility. (Client #4) The finding includes: On March 23, 2011, at 10:12 a.m., an unopened box of nasal spray was observed being stored in a refrigerator located in the front office area upstairs. The box's label indicated that it was Client #4's "Calcitonin-Salmon 3.7 ml 200 U/Dose Spray, 1 spray in alternating nostril every day." Continued review of the label revealed that the prescription had been filled on March 6, 2011 and "refrigerate until opened. Store at room | W 381 | | |

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| W 381 | Continued From page 14 temperature after opening..." There was no lock observed on the refrigerator door. At 10:56 a.m., the medication nurse who had administered the clients' medications earlier that morning was asked if any medications required refrigeration. While she stated that Client #4's nasal spray was stored in a refrigerator before opening, she walked to the refrigerator, opened the door and pointed to the box of nasal spray that was being stored in the door. She closed the refrigerator. She was then asked if there was a means of locking the refrigerator. She paused, then acknowledged that the nasal spray was not properly secured. She reopened the refrigerator and transferred the box of nasal spray to another refrigerator that was located in the adjoining nurse's office. She explained that the new location was secure, given that the door to the nurse's office was kept locked whenever nursing staff were not present. | W 381 | Medications that must be refrigerated in the future will be stored in lock boxes that are appropriately labeled...5-14-11 The relevant medication passing nurses will be retrained on the proper storage of medications by the DON by...5-20-11 Medication storage will be checked at minimum twice monthly by the nursing team...5-1-11 | | |
| W 418 | 483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a comfortable mattress, for four of the five clients residing in the facility. (Clients #1, #2, #3 and #5) The findings include: On March 23, 2011, at 8:24 a.m., the medication nurse was observed applying Derma-Smooth oil | W 418 | | | |

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| W 418 | Continued From page 15 to Client #2's scalp while in the privacy of her bedroom. Observation of Client #2's bed revealed a large indentation at the center of the mattress. Later that day, at 4:23 p.m., the beds used by Clients #3 and #5 also were observed with large indentations in their mattresses. At 4:27 p.m., while interviewing Client #1 in his bedroom, his mattress also was observed to be sunken. | W 418 | W418 New Mattresses have been ordered and will be in place by...5-20-11 The facility manager will monitor the condition of all furniture during bi-monthly environmental audits and will report any repair needs for timely follow up...5-1-11 | |
| W 440 | 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On March 24, 2011, at 4:05 p.m., interview with the house manager (HM) revealed that there were three designated shifts (8:00 a.m. - 4:00 | W 440 | | |

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| W 440 | <p>Continued From page 16</p> <p>p.m.; 4:00 p.m. - 12:00 a.m.; and, 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) on Saturdays and Sundays.</p> <p>The facility's fire drill log records for the period January 2010 - February 2011 were reviewed on the same day, beginning at 4:06 p.m. There were no documented drills held during the 8:00 a.m. - 8:00 p.m. shift on weekends for the first ten (10) months. Beginning October 30, 2010, however, there had been a drill conducted on that shift every month.</p> <p>Similarly, there was no evidence that drills were conducted during the 8:00 p.m. - 8:00 a.m. shift on weekends from January 1, 2010 until June 27, 2010. Since then, the weekend overnight staff documented evacuation drills on June 27, 2010, September 26, 2010 and January 29, 2011.</p> <p>When interviewed on March 24, 2011, at approximately 4:45 p.m., the facility's HM and qualified intellectual disabilities professional acknowledged that the weekend shifts had not conducted drills in early-mid 2010. They reportedly addressed the deficient practice in staff meetings, once it had been identified. Moments later, however, they acknowledged that four months had passed between overnight drills conducted on September 26, 2010 and January 29, 2011.</p> | W 440 | <p>W440</p> <p>The staff will be retrained on the importance of following the fire drill schedule, implementing drills properly as prescribed by the schedule and reporting any concerns to the management team. Proper documentation will also be covered...5-11-11</p> <p>MTS maintains an annual fire drill schedule for each home that reflects at minimum one drill per quarter for each shift. The QIDP will monitor the implementation of the schedule to insure that all scheduled drills are implemented and will insure that any drill missed is made up within one week...5-20-11</p> | |
| W 473 | <p>483.480(b)(2)(ii) MEAL SERVICES</p> <p>Food must be served at appropriate temperature.</p> | W 473 | | |

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|---|---|
| NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019 |
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|--------------------|--|---------------|--|----------------------|
| W 473 | <p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was served at the appropriate temperature, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On March 23, 2011, at 7:25 a.m., upon entry into the facility a covered plate of food was observed sitting on the dining room table. Interview with a direct care staff at 8:20 a.m., indicated that the covered plate was Client #3's. The staff further indicated that the client eats after she receives her medications (Reglan). At 8:30 a.m., the direct care staff was observed removing the covering from the plate and began feeding Client #3 her breakfast.</p> <p>Interview with the qualified intellectual disabilities professional on March 23, 2011, at approximately 2:30 p.m., revealed that Client #3's food should have been heated if it sat on the table for more than 15 minutes, prior to her eating the meal.</p> | W 473 | <p>W473</p> <p>Staff will be retrained on the importance of following the meal protocol for Client #3 by the nutritionist on...5-11-11 The facility manager will observe meals implemented on all shifts at minimum twice weekly to insure that there is consistent compliance...5-20-11</p> | |

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Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0181 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/25/2011 |
|---|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4414-16 JAY STREET, NE WASHINGTON, DC 20019 | | |
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| 1000 | INITIAL COMMENTS A licensure survey was initiated on March 23, 2011 and was concluded on March 25, 2011. A sample of three residents was selected from a population of one man and four women with varying degrees of intellectual disabilities. The findings of the survey were based on observations and interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports. | 1000 | | |
| 1049 | 3502.7 MEAL SERVICE / DINING AREAS Each GHMRP shall serve meals at proper temperatures. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was served at the appropriate temperature, for one of the three residents in the sample. (Resident #3) The finding includes: On March 23, 2011, at 7:30 a.m., upon entry into the facility a covered plate of food was observed sitting on the dining room table. Interview with a direct care staff at 8:30 a.m., indicated that the covered plate was Resident #3's. The staff further indicated that the resident eats after she receives her medications (Reglan). At 9:00 a.m., the direct care staff was observed removing the covering from the plate and began feeding Resident #3 her breakfast. | 1049 | Chapter 35 3502.7 Staff will be retrained on the importance of following the meal protocol for Client #3 by the nutritionist on...5-11-11 The facility manager will observe meals implemented on all shifts at minimum twice weekly to insure that there is consistent compliance...5-20-11 | |

Health Regulation Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8800

Z0ZF11

If continuation sheet 1 of 13

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0181 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/25/2011 |
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| I 049 | Continued From page 1 Interview with the qualified intellectual disabilities professional on March 23, 2011, at approximately 2:30 p.m., revealed that Resident #3's food should have been heated if it sat for more than 15 minutes, prior to her eating the meal. | I 049 | | |
| I 090 | 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 Persons with Intellectual Disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The findings include: On March 25, 2011, beginning at 3:30 p.m., a walk-through inspection of the facility revealed the following: 1. The interior and exterior of the front door (left side) was scratched up. It appeared to be from the wheelchairs. 2. Walls throughout the facility (downstairs) were splotchy. | I 090 | 3504.1 1. The door will be scrapped and repainted. MTS is obtaining estimates at present. The door will be addressed by...5-30-11 2. Same as #1 above...5-30-11 | |

Health Regulation Administration

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| 1090 | Continued From page 2 3. Residents #3 and #5's nightstands and decorations on the walls were extremely dusty. 4. The door to the bedroom shared by Residents #3 and #5 had a hole in it. 5. The carpet leading to bedroom shared by Residents #3 and #5 was stained. 6. The carpet leading from the entrance foyer into the living room had ragged edges, which presented a potential trip hazard. 7. There was a significant amount of grease observed on a ceiling vent in the kitchen. 8. There was a hole in the ceiling of the entrance foyer. After the environmental inspection, the facility's house manager verified the above-cited deficiencies by visual inspection. | 1090 | 3. The nightstands and walls were cleaned...3-25-11 Staff was retrained on consistently cleaning and dusting as directed and per the daily chores schedule...3-26-11 4. The door hole will be addressed by...5-30-11 5. The carpet will be replaced. MTS is currently obtaining bids. The carpet will be replaced by 5-30-11 6. Carpet was cut to eliminate trip hazard during the survey...3-24-11 7. Vent replaced...4-1-11 8. Hole will be addressed by...5-30-11 The facility manager will inspect the environment bi-monthly and report issues found to management for timely follow up. The facility manager will check the completion of household chores by staff at minimum three times weekly to insure that routine cleaning and organizing are done consistently...5-1-11 | |
| 1135 | 3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. 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 hold evacuation drills quarterly on all shifts, for five of the five residents of the facility. (Residents #1, #2, #3, #4 and #5) The finding includes: | 1135 | | |

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| I 135 | <p>Continued From page 3</p> <p>The GHPID failed to conduct simulated fire drills at least four times (4) a year for the weekend shifts, as evidenced below:</p> <p>On March 24, 2011, at 4:05 p.m., interview with the house manager (HM) revealed that there were three designated shifts (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; and, 12:00 a.m. - 8:00 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (8:00 a.m. - 8:00 p.m. and 8:00 p.m. - 8:00 a.m.) on Saturdays and Sundays.</p> <p>The facility's fire drill log records for the period January 2010 - February 2011 were reviewed on the same day, beginning at 4:06 p.m. There were no documented drills held during the 8:00 a.m. - 8:00 p.m. shift on weekends for the first ten (10) months. Beginning October 30, 2010, however, there had been a drill conducted every month on that shift.</p> <p>Similarly, there was no evidence that drills had been conducted between January 1, 2010 and June 27, 2010 during the 8:00 p.m. - 8:00 a.m. shift on weekends. Since then, the overnight staff documented evacuation drills on June 27, 2010, September 26, 2010 and January 29, 2011.</p> <p>When interviewed on March 24, 2011, at approximately 4:45 p.m., the facility's HM and qualified intellectual disabilities professional acknowledged that the weekend shifts had conducted drills in early-mid 2010. They reportedly addressed it in staff meetings once the deficient practice was identified. Moments later,</p> | I 135 | <p>3505.5</p> <p>The staff will be retrained on the importance of following the fire drill schedule, implementing drills properly as prescribed by the schedule and reporting any concerns to the management team. Proper documentation will also be covered...5-11-11</p> <p>MTS maintains an annual fire drill schedule for each home that reflects at minimum one drill per quarter for each shift. The QIDP will monitor the implementation of the schedule to insure that all scheduled drills are implemented and will insure that any drill missed is made up within one week...5-20-11</p> | |

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| I 135 | Continued From page 4 however, they acknowledged that four months had passed between overnight drills conducted on September 26, 2010 and January 29, 2011. | I 135 | | |
| I 206 | 3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. 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 each employee had a current health certificate, for three of the twelve staff. [director of nursing (DON), qualified intellectual disabilities professional (QIDP) and one of the four nurses (Staff #3)] The finding includes: On March 24, 2011, beginning at 2:50 p.m., review of personnel records revealed no evidence of current health certificates for the DON and Staff #3. There was no employee record made available for review for the QIDP therefore, the survey team was unable to verify that the QIDP had a current health inventory/ certificate. Interview with the house manager on March 25, 2011, at approximately 12:30 p.m., confirmed that there was no evidence of current health | I 206 | 3509.6 The updated health certificates will be obtained by...5-30-11 MTS is developing a auditing and tracking format for all personnel file considerations that will insure proactive discovery and follow up. This function will be housed in HR and will be functional by...6-30-11 The QIDP and DON have current health certificates (See attachments). | |

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| I 208 | Continued From page 5 certificates for the QIDP, DON and Staff #3. No additional information was presented before the survey ended later that afternoon. | I 206 | | |
| I 227 | 3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to show evidence that the qualified intellectual disabilities professional (QIDP) had current training to implement emergency measures. The finding includes: There was no employee record made available for review on March 24, 2011, beginning at 2:50 p.m. Without a file to review, the survey team was unable to verify that the QIDP had a current certification on Cardiopulmonary Resuscitation (CPR) and first aid training. Interview with the house manager on March 25, 2011, at approximately 12:30 p.m., confirmed that the QIDP's file was not available for review. | I 227 | 3510.5(d) The QIDP has current CRP and first aid certification (See attached copies)...5-1-11 MTS will insure that a copy of the QIDP's file is maintained in the home personnel files and that it is updated as required...5-1-11 | |
| I 229 | 3510.5(f) STAFF TRAINING | I 229 | | |

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| I 229 | <p>Continued From page 6</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(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;</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 that all staff were effectively trained and competent to provide assistance in accordance with the residents' prescribed mealtime needs, for one of the three residents in the sample. (Resident #1)</p> <p>The findings include:</p> <p>Resident #1 was observed at breakfast on March 23, 2011, beginning at 6:50 a.m. After presenting the resident's plate, a direct support staff informed him what he was about to eat. At 6:52, the staff placed a specialized, angled spoon into the resident's right hand, held the resident's hand with his own and began feeding him with hand over hand support. The resident, however, was resistive and food spilled onto his chin and bib. The staff asked him "you want me to feed you?" After a 10-second pause, the staff answered for him "yeah." After another 10-second pause, the staff said "let's try one more time." He resumed hand over hand assistance and the resident again refused to cooperate. By 6:54 a.m., the staff was spoon feeding the resident his breakfast. Staff spoon</p> | I 229 | | |

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| I 229 | Continued From page 7 fed him throughout the rest of his meal. Resident #1 was observed at his day program on March 23, 2011. At 12:05 p.m., a day program staff opened an aluminum tray of warm foods (pureed turkey, macaroni and cheese, and sweet potatoes). He transferred the foods into a scoop plate and placed a specialized, angled spoon on the side of the plate. At approximately 12:07 p.m., another day program staff placed the spoon into the resident's right hand, held the resident's hand using both of her hands and began feeding him. Even though Resident #1 resisted her hand over hand support, she persisted and he participated to that extent (hand over hand) throughout the remainder of his meal. Staff at the day program were observed referring to a mealtime protocol (MP), dated July 2010, which resembled the same one that had been observed in the kitchen earlier that day in the home. Resident #1 was observed receiving snack in his home later that afternoon, at 4:28 p.m. After offering him a choice of snack items, a direct support staff was observed using the same technique used by the day program staff at lunch (using both hands to provide hand over hand support) while feeding the resident a serving of yogurt. 1. On March 24, 2011, at 9:37 a.m., review of Resident #1's MP, dated July 2010, revealed the following instructions: "Encourage <resident's name> to eat without physical support of staff. If he will not eat after 3-5 minutes of encouragement, provide hand over hand support with fading to promote independence." The | I 229 | 3510.5(f) The QIDP will meet with the day program staff of Client #1 to insure that the program has the prescribed sectional plate and to insure that it is used consistently. Additionally, the QIDP will reinforce the importance of encouraging Client #1 to eat with as little staff support as possible. The QIDP will document the follow up in the monthly notes...5-22-11 The QIDP provided the day program with a new plate.. 5-2-11 The QIDP and other support staff will monitor compliance during routine visits to the program (minimum monthly). Failure to use the prescribed sectional plate or provide support during the meal as per the prescribed protocol will be reported to the management levels of the day program for follow up...5-22-11 The QIDP provided additional training for the home staff to reinforce the importance of following the meal protocol for Client #1...3-24-11 The QIDP will monitor meals at minimum once weekly for all shifts to insure that the meal protocol is consistently followed. The facility manager will observe meals for all shifts at minimum twice weekly (separate from the QIDP observations) to insure routine compliance. Any failures to follow the protocols during observations will result in appropriate follow up action (on-the-spot training, counseling, disciplinary follow up, etc.)...5-22-11 The QIDP will schedule a formal training by the OT to reinforce the proper use of the sectional plate and implementation of the meal protocol...5-30-11 | |

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| I 229 | Continued From page 8 three different staff observed in the home and at day program were all observed to give the resident hand over hand support immediately, without first offering him encouragement to feed himself (for a period of 3-5 minutes), in accordance with the MP. 2. During the day program visit, at 12:24 p.m., interview with the direct support staff assisting Resident #1 at lunch revealed that she had been employed there "for a year." When asked if she had received training on his MP, she replied "yeah, I do hand over hand with him." Interview with the qualified intellectual disabilities professional (QIDP) on March 25, 2011, beginning at 9:50 a.m., revealed that she had observed a lunch at day program approximately two months prior to the survey. When asked at 10:39 a.m., if staff at the day program had received training on Resident #1's MP, the QIDP stated that an LPN had provided training in the past "but not this one," referring to the July 2010 revisions. There was no evidence that staff at Resident #1's day program had received effective training on implementing his MP. 3. In-service training records for residential staff were reviewed on March 24, 2011, beginning at 2:51 p.m. The facility had documented a October 12, 2010 training by the Occupational Therapist regarding residents' mealtime protocols. Review of the staff signature sheets revealed that nine (9) staff, including the man observed assisting Resident #1 at breakfast (6:50 a.m.) on the day before had been in attendance. There was no signature, however, of the staff that was observed assisting the resident with his yogurt at 4:28 p.m. There was no | I 229 | | |

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| I 229 | Continued From page 9 evidence that staff in Resident #1's home had received effective training on implementing his MP. This is a repeat deficiency. _____ | I 229 | | |
| I 422 | 3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. 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 that residents received habilitation and assistance as prescribed in their Individual Support Plan, for one of the three residents in the sample. (Resident #3) The finding includes: During snack observations on March 23, 2011, at 4:15 p.m., the direct care staff offered Resident #3 a variety of snacks. After she completed her snack, staff presented a communication device. The device had pictures of a person eating, waving hello and good-bye, and strolling in a wheelchair. Once a picture was | I 422 | | |

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| 1422 | Continued From page 10 pushed the word was said. Staff was observed pushing the picture of a person eating, to which one could hear a recorded message "I am hungry." Interview with the direct care staff, at 4:50 p.m., revealed that the resident used the device to express her wants. On March 25, 2011, beginning at 9:25 a.m., review of Resident #3's IPP dated May 24, 2010, revealed a program objective which stated, "[the resident] will be able to use a voice output/picture communication symbols in order to express some of her fundamental needs, wants and desires given gestural cues on 3 out of 4 trials." On March 24, 2011, at 11:55 a.m., review of Resident #3's speech assessment, dated July 23, 2010, revealed that she had severe speech and language deficits. The assessment recommended that the resident receive exposure to cause and effect activities to increase her overall responsiveness. Interview with the qualified intellectual disabilities professional on March 25, 2011, at approximately 12:15 a.m., revealed that the resident should use her communication device to express her wants, needs and/or desires prior to the selection presented to her. The staff, however, failed to implement Resident #3's communication goal as written, on the previous evening. They did not present the voice output/picture communication board to Resident #3 prior to (or during) snack time. | 1422 | 3521.3 The QIDP re-trained staff on the proper use of Client #3's communications device...4-15-11 The QIDP will schedule a formal, follow up training session by the speech pathologist. This training will occur by...5-30-11 The Speech Pathologist will be asked to develop a formal protocol for staff to follow in supporting Client #3 in the use of the communications device...5-30-11 The QIDP will observe the implementation of this program during routine monthly active treatment observations and will provide on-the-spot training to staff if any is observed failing to properly support Client #3 in using the communications device to express her needs...5-15-11 | |
| 1480 | 3522.7 MEDICATIONS Medication, requiring refrigeration shall be | 1480 | | |

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| I 480 | <p>Continued From page 11</p> <p>maintained either in a separate and secure medication refrigerator or, if in a refrigerator with foods, shall be in a secure and closed compartment or container so as to prevent cross contamination.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that medications requiring refrigeration were properly secured, for one of the five residents of the facility. (Resident #4)</p> <p>The finding includes:</p> <p>On March 23, 2011, at 10:12 a.m., an unopened box of nasal spray was observed being stored in a refrigerator located in the front office area upstairs. The box's label indicated that it was Resident #4's "Calcitonin-Salmon 3.7 ml 200 U/Dose Spray, 1 spray in alternating nostril every day." Continued review of the label revealed that the prescription had been filled on March 8, 2011 and "refrigerate until opened. Store at room temperature after opening..." There was no lock observed on the refrigerator door.</p> <p>At 10:56 a.m., the medication nurse who had administered the residents' medications earlier that morning was asked if any medications required refrigeration. While she stated that Resident #4's nasal spray was stored in a refrigerator before opening, she walked to the refrigerator, opened the door and pointed to the box of nasal spray that was being stored in the door. She closed the refrigerator. She was then asked if there was a means of locking the</p> | I 480 | <p>3522.7</p> <p>Medications that must be refrigerated in the future will be stored in lock boxes that are appropriately labeled ...5-14-11</p> <p>The relevant medication passing nurses will be retrained on the proper storage of medications by the DON by...5-20-11</p> <p>Medication storage will be checked at minimum twice monthly by the nursing team...5-1-11</p> | | |

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| I 480 | Continued From page 12 refrigerator. She paused, then acknowledged that the nasal spray was not properly secured. She reopened the refrigerator and transferred the box of nasal spray to another refrigerator that was located in the adjoining nurse's office. She explained that the new location was secure, given that the door to the nurse's office was kept locked whenever nursing staff were not present. | I 480 | | | |