

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

PRINTED: 01/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

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

W 000 INITIAL COMMENTS

A recertification survey was conducted from 12/22/2010 through 12/23/2010. The survey was initiated and completed utilizing the fundamental survey process.

A random sampling of two clients was selected from a residential population of four females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the client and administrative records, including the incident reports.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for one of two sampled clients. [Client #2]

The findings include:

1. The QMRP failed to ensure the mobility needs of its clients by ensuring the provision or use of their recommended adaptive equipment. [See W436]
2. [Cross Reference W436]

W 000

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

RECEIVED
1-4-11

W 159

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Catherine A. Reese</i>	TITLE <i>Program Director</i>	(X6) DATE <i>1/14/11</i>
--	----------------------------------	-----------------------------

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: 01/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

(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 Continued From page 1

Observation at the residential facility during the survey on 12/22/2010 and again on 12/23/2010 revealed Client #2 ambulated with an unsteady gait.

Record review on 12/23/2010, at approximately 2:00 p.m. revealed Client #2 's orthopedic assessment dated 6/14/2010 recommended she, " use rolling walker for ambulation ... refer to PT for gait training with walker. "

Interview with the qualified mental retardation professional revealed two separate Physical Therapists have provided separate assessments on 7/15/2010 and again on 10/23/2010 to assess Client #2 's mobility. Further record review revealed, Client #2 has yet to receive any of the " gait trainings with walker " as recommended by the orthopedist.

The facility 's QMRP failed to ensure that the orthopedic specialists recommendation had been addressed.

3. On 12/23/2010 at approximately 11:40 a.m., the day program staff was observed assisting Client #2 as she navigated around her environment. Client #2 walks with an unsteady gait.

Interview with the day program 's case manager (CM) on the same day at approximately 12:10 p.m. revealed the day program convened an interdisciplinary team (IDT) meeting back on 5/2010 to address her unsteady gait and the need for one-to-one assistance. According to the CM, their current staffing allotment does not allow for the one-to-one assistance that Client #2 requires. The CM further added that the IDT agreed Client

W 159

The physical therapist and IDT has agreed that the walker is deemed unsafe for [REDACTED]. This has been consulted with her PCP who agrees as well. A case conference was conducted on 1/10/11 with this recommendation in writing.

1/10/11

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

**PRINTED: 01/06/2011
FORM APPROVED
OMB NO. 0938-0391**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
--	--

(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 Continued From page 2

#2 should be provided the additional staffing support to manage her unsteady gait.

Record review at the day program on the same day at approximately 12:15 p.m. confirmed an IDT meeting was held on 5/19/2010 to address the ambulation problems Client #2 was having at the day program.

Interview and record review with the facility's qualified mental retardation professional (QMRP) on 12/23/2010 at 1:42 p.m. confirmed the IDT had agreed Client #2 should be provided with one-to-one staffing services on 5/19/2010, but as of the date of survey, the one-to-one staffing was still not in place.

The facility's QMRP failed to ensure the timely implementation of Client #2's one-to-one services.

W 159

W 436 483.470(g)(2) SPACE AND EQUIPMENT

The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the mobility needs of its clients by providing the necessary adaptive equipment for one of two sampled clients. [Client #2]

The finding includes:

W 436

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

**PRINTED: 01/08/2011
FORM APPROVED
OMB NO. 0938-0391**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
--	--

(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 436 Continued From page 3

W 436

Observation on 12/22/2010 and on 12/23/2010 revealed Client #2 walked with an unsteady gait as she navigated her way around her home. No adaptive equipment was observed being used by her or by the staff to assist her to get around.

Review of the incident reports on 12/22/2010 at 9:38 a.m. revealed an incident report dated 7/14/2010 detailing Client #2 sustained a scrape on her left elbow when she lost her balance and fell while being escorted to the van in the morning on her way to her day program. The incident report documented that the fall occurred when the van attendant let go of her hand as he attempted to open the door of the van to escort her on.

Further review of Client #2 ' s medical and habilitation records on the same day beginning at 1:37 p.m. revealed the following recommendations:

1. Physical therapy assessment dated 5/16/2010 outlined, " [Client #2] should use a gait belt at all times with ALL ambulatory activities ...Strongly consider the use of rolling walker for [Client #2] to improve stability with her gait. "
2. Orthopedic assessment dated 8/14/2010 recommended Client #2, " use rolling walker for ambulation ... refer to PT for gait training with walker. "
3. The interdisciplinary team met on 7/8/2010 and all parties in attendance agreed a second opinion should be obtained from a different physical therapist (PT) with regards to the recommendation that Client #2 should be provided a rolling walker.

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

PRINTED: 01/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

(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 436 Continued From page 4

W 436:

4. Physical therapy assessment dated 7/15/2010 recommended, " [Client #2] will benefit from the use of a walker ... Gait belt should be used for safety. "

5. Physician 's (telephone) order dated 9/27/2010 prescribed the facility should " use wheelchair during community outings in and out of the house for medical appointments. "

6. Physical therapy assessment dated 10/23/2010 " highly recommended that the client use a helmet while ambulating and with all transitional activities. " The same assessment further recommended that " ...caregivers [to] use a gait belt with transitional activities and ambulation. "

Interview with qualified mental retardation professional (QMRP) on 12/23/2010 at 2:32 p.m. revealed none of the adaptive equipment recommended above was currently in use. According to the QMRP, the gait belt and the wheelchair were ordered back in 6/2010. In addition, the QMRP further added that the delay for implementing any of the adaptive equipment was due to the IDT planning a second meeting in 1/2011 to meet with Client #2 's mother. Client #2's mother has concerns with the recommendations that her daughter be considered or provided a helmet, rolling walker, wheelchair, and gait belt.

Further interview and record review with the QMRP on the same day and time confirmed Client #2 's gait belt and wheelchair were purchased on 6/8/2010 and were currently available for use, but had yet to be implemented.

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

PRINTED: 01/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

(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 436 : Continued From page 5

The facility failed to ensure the timely implementation of any of Client #2 's recommended adaptive equipment.

W 436

The team conducted a case conference on 1/10/11 in which all adaptive equipment for [redacted] was discussed. The team agreed the wheelchairs, gait belt, and one/one services would benefit [redacted]. The walker was deem unsafe, and the helmet not required at this time. The team recommendations have been documented in writing.

1/28/11

PRINTED: 01/06/2011
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

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

1 000	INITIAL COMMENTS A re-licensure survey was conducted from 12/22/2010 to 12/23/2010. A random sampling of two residents was selected from a population of four females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the habilitation and administrative records, including the incident reports.	1 000		
1 090	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 staff interview, the facility failed to ensure the maintenance and upkeep of the wheel chair accessible ramp on the rear/side of the facility. The finding includes: Observation on 12/22/2010 at approximately 4:05 p.m. revealed one of the wooden planks on the rear ramp leading to the front of the facility was broken and jitted out onto the walkway. Interview with the facility's qualified mental retardation professional (QMRP) on 12/23/2010 at approximately 4:30 p.m. revealed she would contact the maintenance contractor to get the broken railing repaired.	1 090	The wooden plank on the rear ramp leading to the front of the facility will be repaired.	1/14/11

Health Regulation Administration
Catherine A. Reese
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Program Director
 (X6) DATE
 1/14/11
 STATE FORM 27-1000 YLLH11 If continuation sheet 1 of 1

PRINTED: 01/08/2011
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018		
(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 183	Continued From page 1	I 183		
I 183	3508.4 ADMINISTRATIVE SUPPORT	I 183		
	Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.			
	This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP's qualified mental retardation professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for one of two sample residents. [Residents #2]			
	The findings include:			
	1. The QMRP failed to ensure the mobility needs of its residents by ensuring the provision or use of their recommended adaptive equipment. [See Federal Deficiency Report Citation W436]		1. Cross reference W436	1/28/11
	2. The facility's QMRP failed to ensure Resident #2 was provided physical therapy intervention as outlined by the attending orthopedic specialist [Cross Reference Federal Deficiency Report Citation W436]		2. Cross reference W436	1/28/11
	3. On 12/23/2010 at approximately 11:40 a.m., the day program staff was observed assisting Resident #2 as she navigated around her environment. Resident #2 walks with an unsteady gait.		3. The QMRP will submit a one/ one package to Individual #2 Service Coordinator requesting one/ one services.	1/28/11
	Interview with the day program's case manager (CM) on the same day at approximately 12:10 p.m. revealed the day program convened an interdisciplinary team (IDT) meeting back on 5/2010 to address her unsteady gait and the need for one-to-one assistance. According to the CM,			

PRINTED: 01/08/2011
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

(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 183	<p>Continued From page 2</p> <p>their current staffing allotment does not allow for the one-to-one assistance that Resident #2 requires. The CM further added that the IDT agreed Resident #2 should be provided the additional staffing support to manage her unsteady gait.</p> <p>Record review at the day program on the same day at approximately 12:15 p.m. confirmed an IDT meeting was held on 5/19/2010 to address the ambulation problems Resident #2 was having at the day program.</p> <p>Interview and record review with the facility's qualified mental retardation professional (QMRP) on 12/23/2010 at 1:42 p.m. confirmed the IDT had agreed Resident #2 should be provided with one-to-one staffing services on 5/19/2010, but as of the date of survey, the one-to-one staffing was still not in place.</p> <p>The facility's QMRP failed to ensure the timely implementation of Resident #2's one-to-one services.</p>	I 183		
-------	---	-------	--	--

I 202	<p>3509.2 PERSONNEL POLICIES</p> <p>Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was provided a written job description as required by this section. [Staffs #2 and #5]</p>	I 202	<p>The QMRP will ensure that all staff have a written job description signed in their personnel folders. In the future, the QMRP will review job descriptions annually with staff and have them signed.</p>	1/28/11
-------	---	-------	---	---------

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2838 MYRTLE AVENUE NE WASHINGTON, DC 20018
---	--

(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 202	Continued From page 3 The finding includes: Record review and interview with the GHMRP ' s qualified mental retardation professional (QMRP) on 12/23/2010 at approximately 3:45 p.m. confirmed two out of twelve staff was without a written job description in their personnel files.	I 202		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure two out of twelve staff was provided the opportunity to annually review their written job descriptions as required by this section. [Staff #2 and #6] The finding includes: Record review and interview with the GHMRP ' s qualified mental retardation professional (QMRP) on 12/23/2010 at approximately 3:45 p.m. confirmed two out of twelve staff was not provided the opportunity to review their written job descriptions over the past year.	I 203	Cross reference 1202	1/28/11
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	I 227		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/23/2010	
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018		
(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 227	<p>Continued From page 4</p> <p>evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure all staff were currently certified to perform first aid treatment and care. (Staff #1, #2 and #3)</p> <p>The finding includes:</p> <p>Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 12/23/2010 at approximately 3:15 p.m. confirmed three out of twelve staff was not currently first aid certified.</p>	I 227	<p>1. The nursing staff will provide training in first aid to staff #1, #2 and #3.</p> <p>2. Training records will be reviewed quarterly by the QMRP.</p>	<p>1/30/11</p> <p>1/30/11</p>