

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

PRINTED: 06/17/2009
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 R 05/28/2009
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 130	Continued From page 1 overheard saying to Resident #4 "let me fix your clothes." The staff was observed to lift Resident #4's blouse, exposing her stomach area in the presence of the surveyor and one of her housemates (Resident #1).	W 130	The QMRP/ House Manager will ensure that all resident rights are not being violated. Staff will receive training to address the rights of all individuals.	7/10/09	
W 159	At the time of the survey, the facility failed to ensure Client #4 was provided privacy. 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 interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: During the revisit on May 28, 2009, revealed a Plan of Correction (POC) dated December 19, 2008. Review of the POC revealed that Client #3's Behavior Support Plan (BSP) would be revised to address behavior of food stealing by December 31, 2008. Review of Client #3's BSP on May 28, 2009 revealed that the plan had not addressed the client's food stealing. Interview with the direct care staff on the same day revealed that the client continues to exhibit the food stealing behavior. Additionally, the staff stated that they you can not leave your food unattended, because Client #3	W 159			Client #3's BSP will be revised by the psychologist to address the behavior of food stealing. The QMRP/ House Manager will ensure that all behaviors are addressed in the BSP's of all

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{1 000} INITIAL COMMENTS

A licensure revisit survey was conducted on May 28, 2009. The Plan of Correction for the November 20, 2008 recertification survey, which was submitted by the facility on December 19, 2009, was the focus of this revisit survey. The facility provided services and supports for four females with various disabilities.

The findings of the survey were based on observations in the home and at one day program, interviews with administrative and direct care staff, as well as a review of client and administrative records, including unusual incident reports.

The results of the survey determined the facility maintained substantial compliance with the previously cited deficiencies, however, there were standard level deficiencies.

{1 000}

{1 401} 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.

This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each resident that received psychotropic medications had a psychiatric assessment, for one of the two residents in the sample. (Resident #3)

The finding includes:

{1 401}

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Constantine A. Reese LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program Director

(X6) DATE: 6/26/09

STATE FORM 4Q612 If continuation sheet 1 of 7

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{1 401}	<p>Continued From page 1</p> <p>During the revisit on May 28, 2009, revealed a Plan of Correction (POC) dated December 19, 2008. Review of the POC revealed that Resident #3's Behavior Support Plan (BSP) would be revised to address behaviors of food stealing by December 31, 2008.</p>	{1 401}	Cross reference W159	7/10/09
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	<p>Review of Resident #3's habilitation record on May 28, 2009 revealed a BSP dated November 17, 2008. Continued review of the plan revealed that the evaluation did not address the resident's food stealing. Interview with the direct care staff on the same day revealed that the resident continues to exhibit the food stealing behavior. Additionally, the staff indicated that you should not leave your food unattended, because she will take it.</p> <p>It should be noted that review of Resident #3's habilitation record on the aforementioned date revealed a psychological assessment dated January 16, 2009. Review of the assessment revealed that the resident's targeted behaviors included food stealing, however, at the time of the revisit, there was no documented evidence that Resident #3's BSP had been revised to address the resident's food stealing.</p>			
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1 406	<p>3520.8 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each professional service provided shall be documented in each resident ' s record.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the results of a Venus Doppler was obtained and documented for one of the two residents (Resident #1)</p>	1 406		
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I 406	<p>Continued From page 2 included in the sample.</p> <p>The finding includes:</p> <p>Observation on May 28, 2009, at 9:24 AM revealed transportation services had arrived for Residents #1 and #2. Resident #1 was observed to refuse to get up from her chair when the staff placed her walker in front of her. The direct care staff assisted Resident #1 to a standing position and directed her towards the front door. The resident started screaming when she heading out of the front door and refused to walk down the stairs. The driver attempted to encouraged her to "step down," however, Resident #1 continued to scream and refused to be walkt. The client appeared to be experiencing difficulty ambulate when going down the stairs.</p> <p>It should be noted that it took the direct care staff and the driver from 9:24 AM until 9:34 AM before the client got to the bottom of the front stairs. The resident was given her walker to walk towards the van and was overheard screaming and cursing, telling the staff to get off of her.</p> <p>Interview with staff revealed that Resident #1 exhibits these behaviors each morning before leaving for the day program. At 11:09 AM and interview was conducted with the Qualified Mental Retardation Professional (QMRP) to ascertain information about the resident's unsteady gait. According to the QMRP, the resident had fractured her leg last year and experiences swelling of her ankle sometimes. Continued interview with the QMRP and review of the records revealed that the client was seen by the facility's Physical Therapist (PT) on November 2, 2008. Additionally, the client had a quarterly review conducted by the PT in March</p>	I 406		

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I 406	Continued From page 3 2009. The PT stated that if the client experiences swelling of her ankle she should be seen by an orthopedic, because that is out of his range. Interview with the QMRP and review of the record revealed the resident was seen by an orthopedic specialist on April 6, 2009. The orthopedic specialist recommended a venous doppler for Resident #1's left and right leg to rule out Deep Vein Thrombosis (DVT). Interview with the QMRP and review of the resident's record revealed that the medical consult indicated that the report would be faxed, however, at the time of the survey, there was no documented evidence of the results of the venous doppler.	I 406	The QMRP, Nurse, and House Manager will ensure all medical reports are documented and filed in the medical books for all individuals monthly. The primary care nurse will be requested to follow-up on all labs and specialist recommendations weekly.	6/26/09	
{I 438}	3521.7(h) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (h) Interpersonal and social skills (including sharing, courtesy, cooperation, responsibility and age-appropriate and culturally normative social behaviors and relationships involving peers of the same and different sex, younger and older persons and person in authority); This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure Individual Program Plan (IPP) objectives included training for social behaviors for one of the two residents (Resident #3) included in the sample. The finding includes: During the revisit on May 28, 2009, revealed a	{I 438}			

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{ 438}	Continued From page 4 Plan of Correction (POC) dated December 19, 2008. Review of the POC revealed that Resident #3's Behavior Support Plan (BSP) would be revised to address behaviors of food stealing by December 31, 2008. Review of Resident #3's BSP on May 28, 2009 revealed that the plan had not addressed the resident's food stealing. Interview with the direct care staff on the same day revealed that the resident continues to exhibit the food stealing behavior. Additionally, the staff indicated that you should not leave your food unattended, because she will take it. It should be noted that review of Resident #3's habilitation record on the aforementioned date revealed a psychological assessment dated January 16, 2009. Review of the assessment revealed that the resident's targeted behaviors included food stealing, however, at the time of the revisit, there was no documented evidence that Resident #3's BSP had been revised to address the resident's food stealing.	{ 438}	Cross reference W159	7/10/09
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19)	I 500		

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1500	<p>Continued From page 5</p> <p>that governs the care and rights of persons with mental retardation.</p> <p>The findings include:</p> <p>On May 28, 2009 at 9:36 AM, the facility's direct care staff was observed to take Resident #1's pocketbook from her person. The resident had just been accompanied to the van to be transported to her day program. The surveyor asked the staff why was Resident #1's purse taken from her. According to the staff, the resident was not allowed to take her purse to the day program. Continued interview with the staff revealed that Resident #1's day program had requested that she not bring her purse due to her behaviors that included throwing object such as her pocketbook or anything in it, and stealing from her peers or staff.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on May 28, 2009, at approximately 12:01 PM revealed that when she was hired she was informed that Resident #1 was not allowed to bring her purse to the day program due to her stealing. Further interview with the QMRP and review of the resident's record revealed that the resident had a Behavior Support Plan (BSP) at her day program to address "taking belongings from others." The QMRP was asked if the facility's Human Rights Committee (HRC) was aware that Resident #1 had been restricted from bringing her purse to the day program? According to the QMRP their HRC was not aware that the resident had been prohibited from taking her purse to the day program.</p> <p>Review of Resident #1's record on May 28, 2009, revealed she had a "Facility Bill of Rights" document dated May 7, 2009. According to the</p>	1500		

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I 500	<p>Continued From page 6</p> <p>document it was noted to state that the resident had "the right to ownership and use of personal possessions so as to maintain individuality and personal dignity. The document was signed by the resident's guardian and the facility's QMRP.</p> <p>At the time of the survey, the facility failed to ensure that their "Bill of Rights" for Resident #1 was implemented.</p>	I 500	Cross reference W130.	7/10/09

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{R 000}	<p>INITIAL COMMENTS</p> <p>A revisit licensure survey was conducted on May 28, 2009. The Plan of Correction for the November 25, 2008 recertification survey, which was submitted by the facility on December 19, 2008, was the focus of this revisit survey. The GHMRP provided services and supports for four females with various disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with administrative and direct care staff, as well as a review of client and administrative records, including unusual incident reports.</p>	{R 000}		
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Constance A. Reese
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program Director
TITLE

(X6) DATE

6/26/09