

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

PRINTED: 01/31/2012
FORM APPROVED
OMB NO. 0938-0391

(X4) ID PREFIX TAG AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/19/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2636 MYRTLE AVENUE NE WASHINGTON, DC 20018
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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 1/18/12 through 1/19/12. A sample of two clients was selected from a population of four women with severe intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with staff and clients at the home and at the two day programs, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000	<p>Received 2/9/12</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 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its policies to ensure the health and safety of one of the four clients residing in the facility. (Client #3)</p> <p>The findings include:</p> <p>Cross refer to W153. The facility failed to implement its established policy for reporting allegations of abuse, as follows:</p> <p>1. On 1/18/12, at 1:25 p.m., review of the facility's</p>	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Constance A. Reese (Signature) *Program Director* (Title) 2-9-12 (Date)

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

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W 149	Continued From page 1 "Incident Management Policy" revealed the following: "ALL CMS staff... are required to report their knowledge of an incident immediately..." Further review of the policies and the facility's orientation training regarding incident reporting, at 1:30 p.m. revealed: "If you witness an incident where a person's well being and rights are compromised, it is mandatory and your duty to report the incident even if you are not directly involved." 2. The facility's policies categorized an allegation of abuse as a "Serious Reportable Incident" and any staff accused of such an allegation would be placed on leave, pending the outcome of an investigation. However, according to personnel records, the driver accused of hitting Client #3 on 8/20/11, worked 8-hour shifts, as scheduled, on the next two days (8/21/12 and 8/22/11). During those two days, the driver had access to the four clients living at this facility. On 1/18/12, at 12:26 p.m., continued review of the driver's personnel record revealed that he was placed on "leave without pay" on 8/23/11.	W 149	1. Staff will receive training on incident reporting. Ongoing training of incident reporting will be provided annually. 1. In the future, all staff will be instructed to report all incidents immediately. Disciplinary action up to termination will result when staff fail to report incidents in a timely matter.	2/10/12 2/10/12	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of client records, including incident reports and investigations, the	W 153			

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W 153	<p>Continued From page 2</p> <p>facility failed to ensure that all allegations of abuse were reported immediately to the administrator and the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for one of the four clients residing in the facility. (Client #3)</p> <p>The findings include:</p> <p>On 1/18/12, beginning at 10:54 a.m., review of incident reports in the facility revealed an incident of staff-on-client abuse, dated 8/20/11. Continued review of the incident report, staff witness statements and the corresponding investigation report, dated 9/16/11, revealed the following sequence of events:</p> <p>1. Client #3 bit the driver while the driver was assisting her off the van on 8/20/11, at approximately 1:30 p.m. A direct support staff witnessed the driver hit Client #3 several times on her head. The witness completed the remainder of her shift, and left the facility at 4:00 p.m. without reporting the abuse.</p> <p>2. There were two additional direct support staff working on the 8:00 a.m. - 4:00 p.m. shift on 8/20/11. In their written statements, dated 8/23/11, the two other staff went on record as having knowledge that the driver hit the client, while they were on that shift. Neither staff, however, reported the abuse.</p> <p>3. The staff who witnessed the incident notified the qualified intellectual disabilities professional (QIDP) the next morning (8/21/11). The QIDP then reported the incident to the facility's administrator and the incident management</p>	W 153	<p>2. Staff will receive training on incident reporting by the Incident Management Coordinator.</p> <p>3. Incident reports and investigations will be completed by QIDP within 5 working days.</p>	<p>2/10/12</p> <p>2/10/12</p>
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W 153	Continued From page 3 coordinator (IMC) one day later (8/22/12). 4. The State agency was notified of the incident on 8/22/11, at 8:25 p.m. (after business hours). The facility failed to ensure that all allegations of abuse were reported immediately to the administrator and to HRLA.	W 153	4. The QIDP will ensure that the state agency is notified immediately.	2/10/12
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days of all incidents, for one of the four clients residing in the facility. (Client #3) The findings include: Review of the facility's incident management records on 1/18/11, beginning at 10:54 a.m., revealed that on 8/20/11, at approximately 1:30 p.m., a direct support staff witnessed a driver hit Client #3 several times on her head while disembarking the facility's van. Review of the corresponding investigative report revealed the investigation was initiated on 8/22/11 and completed on 9/16/11 (27 days after the incident occurred). The allegation of abuse was substantiated. There was no documented evidence that the administrator was informed of	W 156	Cross reference W153	2/10/12

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W 158	Continued From page 4 the investigation results prior to 9/16/11. On 1/18/12, at 1:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that the facility's administrator routinely was kept informed "throughout the investigation... constant communication... to the point at which it was substantiated." The QIDP acknowledged, however, that this was not documented in writing. At the time of the survey, the facility failed to provide documented evidence the administrator was notified of the results of the investigation within 5 working days, as required by federal regulation.	W 158			
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 intellectual disabilities Professional (QIDP) failed to ensure the coordination, monitoring, and implementation of a clients' habilitation and planning for two of the two sampled clients. (Clients #1 and #2) The findings include: 1. The QIDP failed to ensure each staff received initial and ongoing training on universal precautions. [See W189] 2. The QIDP failed to ensure staff implemented	W 159	1. Staff will receive ongoing training on Safety and Infection Control by primary care nurse.	2/10/12	

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W 159	<p>Continued From page 5 clients' adaptive equipment protocols as written. [See W153]</p> <p>3. The QIDP failed to ensure staff properly documented clients' targeted behaviors. [See W252]</p> <p>4. The QIDP failed to ensure staff offered the clients choices regarding afternoon snacks items. [See W247]</p> <p>5. Observation on 1/18/12, beginning at 3:26 p.m., revealed Client #2 and #3 were engaged in a verbal confrontation during their evening snack. Shortly thereafter, Client #2 was provided a set of large Lego blocks to work with as part of her evening activities. Client #2 remained agitated and continuously tossed the Leggo pieces around the dining room up until the onset of dinner, at 5:10 p.m. Record review on 1/19/12, at 9:53 a.m., revealed Client #2's BSP dated 1/12/12, identified "throwing objects" as one of her targeted behaviors. The plan identified the following interventions: "Staff will model appropriate responses to upsetting actions of others both verbally and non-verbally ... Staff will respond to [Client #2] physical aggression towards others by immediately stopping the actions and then demonstrating appropriate techniques to get her needs met." At no time during the evening was staff observed implementing the measures outlined above to manage Client #2's maladaptive behavior of "throwing blocks." Interview with the facility's qualified intellectual</p>	W 159	2. Gait belt training will be provided by the primary care nurse. QIDP will monitor the implementation of the correct strategies.	2/10/12	
			3. QIDP will provide training on accurately collecting and documenting behaviors.	2/10/12	
			4. Staff will receive additional training on how to provide individuals with choices by QIDP.	2/10/12	
			5. Additional training will be provided on Client #2's BSP on 2/10/12 by QIDP.	2/10/12	

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W 159	Continued From page 6 disabilities professional (QIDP) on 1/19/12, at 2:30 p.m., revealed its impossible for staff to model or demonstrate appropriate behaviors due to Client #2's deteriorated vision. The facility's QIDP failed to ensure Client #2's BSP met her needs to ensure staff could effectively manage her targeted maladaptive behaviors.	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff received initial and ongoing training on universal precautions, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The finding includes: 1. Cross refer to W454. The facility failed to maintain a sanitary environment to avoid sources and transmission of infection. 2. Cross refer to W455. The facility failed to ensure staff received initial and ongoing training on infection control.	W 189			
W 194	483.430(e)(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.	W 194			
			1. Cross reference W454	2/10/12	
			2. Cross reference W455	2/10/12	

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W 194	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record, review the facility failed to ensure staff was competent in utilizing a client's adaptive equipment, for one of the two sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>Observation on 1/18/12, beginning at 3:15 p.m., revealed Client #2 was assisted to her chair at the dining room table by her attending staff. Client #2 was observed wearing a gait belt and the staff was observed holding the gait belt directly from the rear as she was assisted to her chair. The gait belt was up near the lower portions of Client #2's chest. The staff was also observed standing directly behind Client #2 as she made her way to the dining room chair.</p> <p>Record review on 1/19/12, at 12:00 p.m., revealed a gait belt protocol was in place to manage how staff utilized Client #2's gait belt. The plan goes on to identified the following interventions:</p> <p>"Fasten the gait belt around the individual's waist with the buckle placed in front of the individual ... Place one hand on the portion of the gait belt at the front of the individual's waist and place your other hand on the portion of the gait belt at the individual's back Walk to the side and slightly behind the individual."</p> <p>At no time during the evening was staff observed implementing the measures outlined above to</p>	W 194	<p>Staff will receive additional training on the proper use of the gait belt by the primary care nurse for Client #2. QIDP will monitor proper use of the gait belt daily.</p>	2/10/12
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W 194	Continued From page 8 manage Client #2's ambulation from her rolling walker to the dining room table.	W 194			
W 247	Interview and record review with the facility's qualified intellectual disabilities professional (QIDP) on 1/18/12, at approximately 2:45 p.m., confirmed the staff should have implemented the gait belt protocol as written. As of the date of survey, the staff working with Client #2 failed to properly implement her gait protocol to ensure her health and safety. 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, facility staff failed to ensure client choice during snack, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. On 1/18/12, at 3:10 p.m., observations during snack revealed a direct support staff brought 4 single-serving cups of blueberry yogurt to the dining room table. One yogurt cup was given to each of the four clients. At no time did the staff offer clients the option of having a different snack item. 2. A direct support staff (S2) was interviewed in the living room on 1/18/12, at 4:08 p.m. She confirmed that she had worked on the day before	W 247	Staff will receive training on how to offer individuals choices during snack time.	2/10/12	

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W 247	Continued From page 9 and that the four clients had each received a blueberry yogurt. Further interview revealed the clients also "like wafers and cookies too" and that staff "try to give them all the same thing." 3. On 1/19/12, at 4:11 p.m., the four clients were observed eating snacks at the dining room table. Staff that were assisting at the table stated that the snack consisted of blend of chopped fresh apple, banana and tangerine, topped with yogurt. They then confirmed that the four servings of snack were identical. It should be noted that during the environmental inspection on 1/19/12, at 4:31 p.m., boxes of wafers and graham crackers were observed in a cabinet above the kitchen stove.	W 247		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to document behavior data in accordance with the behavior support plan (BSP), for two of the two clients in the sample. (Clients #1 and #2) The findings include:	W 252	3. Cross reference W159	2/10/12

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W 252	<p>Continued From page 10</p> <p>1. The facility failed to ensure accurate data was collected for Client #1 as outlined in the behavior support plan (BSP), as follows:</p> <p>On 1/18/12, beginning at 3:21 p.m. to 5:36 p.m., evening observations revealed Client #1 was observed to scream loudly forty-six (46) times throughout the evening. Interview with the direct care staff on the same day at approximately 5:30 p.m. revealed Client #1 had a BSP to address her maladaptive behavior of screaming.</p> <p>Record verification of Client #1's BSP, dated 10/28/10, (outdated) on 1/19/12, at approximately 2:30 p.m., verified the client had a maladaptive behavior of screaming. Further review of the BSP revealed data should be documented on every shift and every day.</p> <p>Review of the data collection sheets on 1/19/12, at approximately 3:20 p.m., revealed that staff did not accurately document the observed behaviors that occurred on 1/18/12, during the evening shift.</p> <p>Interview with qualified intellectual disabilities professional (QIDP) on 1/19/12, at approximately 3:50 p.m., confirmed that staff did not document Client #3's behaviors that occurred on 1/18/12.</p> <p>2. Based on observation, staff interview and record review, the facility failed to ensure accurate behavioral data was collected, for one of the two sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>Observation on 1/18/12, beginning at 3:26 p.m.,</p>	W 252	<p>1. Staff will receive training on how to document behaviors for Client #1, the definition of each specified behavior and how to measure the frequency of each behavior. QIDP will monitor data sheet accurately.</p>	2/10/12

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W 252	<p>Continued From page 11</p> <p>revealed Client #2 and #3 were engaged in a verbal confrontation during their evening snack. Shortly thereafter, Client #2 was provided a set of large Lego blocks to work with as part of her evening activities. Client #2 remained agitated and continuously tossed the Leggo pieces around the dining room up until the onset of dinner, at 5:10 p.m.</p> <p>Record review on 1/19/12, at 9:53 a.m., revealed Client #2's BSP dated 1/12/12, identified "throwing objects" as one of her targeted behaviors. The plan went on to require that "time block data will be taken on every shift on target behaviors ..." Review of the behavioral data sheets (ABC Data Sheets) revealed the facility failed to ensure accurate data collection. This surveyor counted seventeen instances of "throwing blocks" and one instance of "pulling the table cloth off the table" during the evening of 1/18/2012. The facility's staff documented Client #2 was involved in twenty-five instances of throwing objects.</p> <p>Interview with the facility's qualified intellectual disabilities professional (QIDP) on 1/19/12, at 3:03 p.m., revealed she would have to provide staff additional training on accurately collecting data.</p> <p>The facility failed to ensure staff accurately collected data on Client #2's targeted behaviors.</p>	W 252		
W 369	<p>483.480(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p>	W 369		

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018
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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 369	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that all drugs were administered without error, for one of the four clients residing in the facility. (Client #3)</p> <p>The finding includes:</p> <p>The morning medication administration was observed on 1/18/12, beginning at 7:20 a.m. At 8:41 a.m., the nurse tried administering eye drops in Client #3's eyes. The client closed both eyes and held her head forward. The nurse used physical guidance to move the client's head back. The client, however, remained uncooperative for the next 5 minutes. At 8:44 a.m., the nurse placed 2 drops on the client's left eye lid, which remained closed; the drops rolled down the client's cheek and the nurse dabbed the moisture with a paper napkin. At 8:45 a.m., the same observations were made with 2 drops applied to the client's closed right eye (moisture dabbed away from cheek with paper napkin). At 8:46 a.m., the client left the area without having received the eye drops effectively.</p> <p>At 8:47 a.m., interview with the nurse revealed that she routinely performed the morning medication administrations in this facility. She stated that Client #3 frequently squinted her eyes and was uncooperative when it came time to administer the eye drops...this was routine behavior. When further queried, the nurse said she was not aware of any known intervention techniques to effectively elicit the client's cooperation.</p>	W 369	<p>Nursing staff will be trained on proper medication administration procedures for eye drops for Client #3.</p>	2/10/12
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W 369	Continued From page 13 On 1/19/12, at 2:33 p.m., review of Client #3's physician's order sheets for January 2012 verified that Client #3 was prescribed the following: "Artificial Tears ophthalmology 1.4% drops. Instill 2 drops in each eye twice daily for dry eyes." At 3:45 p.m., the qualified intellectual disabilities professional (QIDP) was asked about the client's resistance to receiving eye drops. The QIDP indicated that she was aware of the behavior then acknowledged that, to date, she was unaware of any interdisciplinary team discussions, assessments or recommendations to address the behavior.	W 369			
W 454	483.470(f)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection, for four of the four clients included residing in the facility. (Clients #1, #2, #3 and #4) The finding includes: On 1/18/12, at 4:18 p.m., Client #2 was observed to pull the table cloth off of the dining table during a behavior. The napkins fell to the floor and remained there until staff placed them back on the dining table, seven (7) minutes later. Several staff and Client #1 were observed walking past the area in which the napkins had fallen. At approximately 5:13 p.m., staff and clients were observed to use the same napkins that had fallen to the floor to wipe the clients' mouth.	W 454	Staff will receive training on Safety and Infection Control for maintaining a sanitary environment by Primary Care Nurse. QIDP and Primary Care Nurse will monitor daily for improvement.	2/10/12	

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W 454	Continued From page 14 Interview with the direct support staff at approximately 5:40 p.m. on the same day confirmed that the same napkins that had fallen to the floor were used during dinner. Review of the in-service training records on 1/19/12, at approximately 1:40 p.m., revealed that the last documented training on sanitation and infection control was dated 9/8/10. There was no current training on sanitation and infection control located in the in-service training records. This was confirmed through interview with the qualified intellectual disabilities professional (QIDP) on 1/19/12, at 3:04 p.m. The QIDP also stated that the evening staff that worked on 1/18/12, at the group home, was employed less than a year.	W 454		
W 455	At the time of the survey, there was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection. 483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure effective infection control procedures were implemented, for one of two sampled clients. (Client #2) The finding includes: On 1/18/12, beginning at 4:31 p.m., Client #2 was observed playing with Lego building blocks and a	W 455		

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W 455	<p>Continued From page 15</p> <p>baby doll until dinner time. At 5:12 p.m., Client #2 was served baked Cajun fish, egg noodles, steamed cabbage, and a beverage for dinner. The client was not observed to wash her hands before eating. Interview with direct support staff on the same day at approximately 5:40 p.m., confirmed that Client #2 did not wash her hands before eating.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 1/19/12, at approximately 3:00 p.m., revealed there was no handwashing program in place for Client #2. Further interview revealed that there was no current universal precaution training located in the records.</p> <p>Review of the in-service training records on 1/19/12, at approximately 3:04 p.m., confirmed the QIDP's statement. The last training on infection control was documented on 9/8/10.</p> <p>Note: It should be noted that staff who worked on 1/18/12 during the evening shift (4 PM - 12 AM), were employed less than a year.</p>	W 455	<p>Primary Care Nurse will provide training to staff and individuals on proper handwashing procedures. QIDP will monitor daily for implementation.</p>	2/10/12

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1 000 INITIAL COMMENTS

A licensure survey was conducted from 1/18/12 through 1/19/12. A sample of two residents was selected from a population of four women with severe intellectual disabilities. This survey was initiated utilizing the full survey process.

The findings of the survey were based on observations in the home and at two day programs, interviews with staff and residents the home and at the two day programs, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

1 000

1 002 3500.2 GENERAL PROVISIONS

Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter.

This Statute is not met as evidenced by:
Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) licensee and its residence director failed to demonstrate that they understood that the provisions of D.C. Law 2-137, D.C. Code, Title 7, Chapter 13 (formerly Title 6, Chapter 19) govern the care and rights of the facility's four residents. (Residents #1, #2, #3 and #4)

The finding includes:

1 002

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

Program Director
PROGRAM DIRECTOR'S SIGNATURE
2/9/12
(X6) DATE

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1 002	<p>Continued From page 1</p> <p>§ 7-1305.10. Mistreatment, neglect or abuse prohibited; use of restraints; seclusion; "time-out" procedures [Formerly § 6-1970]</p> <p>(f) "A customer's counsel, parent or guardian...shall be notified in writing whenever ...an instance of mistreatment, neglect or abuse occurs."</p> <p>Cross refer to Federal Deficiency Report - Citation W153.</p> <p>On 1/18/12, beginning at 10:54 a.m., review of incident reports and corresponding investigation reports revealed that on 8/20/11, at approximately 1:30 p.m., a direct support staff witnessed a driver hit Resident #3 several times on her head while disembarking the facility's van, after returning from a community outing. The incident report documented that Resident #3's family (mother and sister) were notified of the allegation on 8/22/11. Review of the facility's internal investigation report, dated 9/16/11, revealed that the allegation of abuse had been substantiated.</p> <p>On 1/18/12, at 1:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that she had informed Resident #3's family regarding the results of the internal investigation, and that the allegation of abuse was substantiated. She said this information was shared via telephone conversation with the family. The QIDP then stated that to her knowledge, the family had not received written documentation that the abuse had occurred.</p> <p>[Also see 1292 regarding maintenance of residents' records.]</p>	1 002	<p>In the future, the family will be contacted by written documentation and telephone regarding incidents or allegations of mistreatment, abuse and neglect. Cross reference W153</p>	2/10/12
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I 082	Continued From page 2	I 082		
I 082	<p>3503.10 BEDROOMS AND BATHROOMS</p> <p>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with Intellectual disabilities (GHPID) failed to equip all bathrooms used by residents with paper cups.</p> <p>The findings include:</p> <p>1. On January 19, 2012, at 4:41 p.m., observation of the bathroom that was used by Residents #3 and #4 revealed that there were no paper cups available. An empty cup holder was being stored in a small cabinet on the wall, above the toilet.</p> <p>2. Similarly, at 4:49 p.m., there were no paper cups available in the restroom located adjacent to the bedroom shared by Residents #1 and #2. An empty cup holder was stored in a cabinet above the toilet.</p> <p>The qualified intellectual disabilities professional who was present at the time, acknowledged that there were no paper cups available for resident use in either bathroom.</p>	I 082	<p>Paper cups have been purchased and placed in each individuals bathroom.</p>	2/1/12
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p>	I 180		

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I 180	Continued From page 3 This Statute is not met as evidenced by: Based on staff interview and record review, the GHPID's qualified intellectual disabilities Professional (QIDP) failed to ensure the coordination, monitoring, and implementation of a residents' habilitation and planning for two of the two sampled residents. (Residents #1 and #2) The findings include: 1. The QIDP failed to ensure each staff received initial and ongoing training on universal precautions. [See W189] 2. The QIDP failed to ensure staff implemented residents' adaptive equipment protocols as written. [See W153] 3. The QIDP failed to ensure staff properly documented residents' targeted behaviors. [See W252] 4. The QIDP failed to ensure staff offered the residents choices regarding afternoon snacks items. [See W247] Based on staff interview and record review, the GHPID's qualified intellectual disabilities Professional (QIDP) failed to ensure the coordination, monitoring, and implementation of a residents' habilitation and planning for two of the two sampled residents. (Residents #1 and #2) The findings include: 1. The QIDP failed to ensure each staff received	I 180	1. Cross reference W454 2. Cross reference W194 3. Cross reference W252 4. Cross reference W247	2/10/12 2/10/12 2/10/12 2/10/12

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I 180	<p>Continued From page 4</p> <p>initial and ongoing training on universal precautions. [See W189]</p> <p>2. The QIDP failed to ensure staff implemented residents' adaptive equipment protocols as written. [See W153]</p> <p>3. The QIDP failed to ensure staff properly documented residents' targeted behaviors. [See W252]</p> <p>4. The QIDP failed to ensure staff offered the residents choices regarding afternoon snacks items. [See W247]</p> <p>5. Observation on 1/18/12, beginning at 3:28 p.m., revealed Resident #2 and #3 were engaged in a verbal confrontation during their evening snack. Shortly thereafter, Resident #2 was provided a set of large Lego blocks to work with as part of her evening activities. Resident #2 remained agitated and continuously tossed the Leggo pieces around the dining room up until the onset of dinner, at 5:10 p.m. Record review on 1/19/12, at 9:53 a.m., revealed Resident #2's BSP dated 1/12/12, identified "throwing objects" as one of her targeted behaviors. The plan identified the following interventions: "Staff will model appropriate responses to upsetting actions of others both verbally and non-verbally ... Staff will respond to [Resident #2] physical aggression towards others by immediately stopping the actions and then demonstrating appropriate techniques to get her needs met." At no time during the evening was staff observed implementing the measures outlined above to manage Resident #2's maladaptive behavior of</p>	I 180	<p>1. Cross reference W189</p> <p>2. Cross reference W153</p> <p>3. Cross reference W252</p> <p>4. Cross reference W247</p> <p>5. Cross reference W159 (3) (5)</p>	<p>2/10/12</p> <p>2/10/12</p> <p>2/10/12</p> <p>2/10/12</p> <p>2/10/12</p>
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I 180	Continued From page 5 "throwing blocks." Interview with the GHPID's qualified intellectual disabilities professional (QIDP) on 1/19/12, at 2:30 p.m., revealed its impossible for staff to model or demonstrate appropriate behaviors due to Resident #2's deteriorated vision. The GHPID's QIDP failed to ensure Resident #2's BSP met her needs to ensure staff could effectively manage her targeted maladaptive behaviors.	I 180		
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 all health care professionals had current health certificates, for 3 of the 8 consultants. [psychologist, physical therapist and psychiatrist] The findings include: On 1/19/12, beginning at 9:38 a.m., review of the personnel records failed to show evidence of a current physician's health inventory/ certificate for the following: - psychologist; - physical therapist; and, - psychiatrist.	I 206	Current health certificates will be obtained for psychologist, psychiatrist and physical therapist.	2/10/12

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I 208	Continued From page 6 On 1/19/12, at 2:05 p.m., the qualified intellectual disabilities professional confirmed the findings and further indicated that she would bring it to the attention of their human resources director. No additional information was presented before the survey ended later that day at 5:00 p.m.	I 208		
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, interview and record review, the the group home for persons with intellectual disabilities (GHPID) failed to ensure each staff received initial an ongoing training on universal precautions, for four of four residents residing in the GHPID. (Residents #1, #2, #3, and #4) The findings include: Based on observation, interview and record review, the GHPID failed to ensure effective infection control procedures were implemented, for one of two sampled residents. (Resident #2) The finding includes: On 1/18/12, beginning at 4:31 p.m., Resident #2 was observed playing with Lego building blocks and a baby doll until dinner time. At 6:12 p.m., Resident #2 was served baked Cajun fish, egg noodles, steamed cabbage, and a beverage for	I 226	Cross reference W454	2/10/12

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I 226	Continued From page 7 dinner. The resident was not observed to wash her hands before eating. Interview with direct support staff on the same day at approximately 5:40 p.m., confirmed that Resident #2 did not wash her hands before eating. Interview with the qualified intellectual disabilities professional (QIDP) on 1/19/12, at approximately 3:00 p.m., revealed there was no handing washing program in place for Resident #2. Further interview revealed that there was no current universal precaution training located in the records. Review of the in-service training records on 1/19/12, at approximately 3:04 p.m., confirmed the QIDP's statement. The last training on infection control was documented on 9/8/10. Note: It should be noted that staff who worked on 1/18/12, during the evening shift (4 PM - 12 AM), were employed less than a year.	I 226		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure staff was competent in utilizing a resident's adaptive equipment, for one of the two sampled	I 229	Cross reference W194	2/10/12

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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 229	Continued From page 8 residents. (Resident #2) The finding includes: Observation on 1/18/12, beginning at 3:15 p.m., revealed Resident #2 was assisted to her chair at the dining room table by her attending staff. Resident #2 was observed wearing a gait belt and the staff was observed holding the gait belt directly from the rear as she was assisted to her chair. The gait belt was up near the lower portions of Resident #2's chest. The staff was also observed standing directly behind Resident #2 as she made her way to the dining room chair. Record review on 1/19/12, at 12:00 p.m., revealed a gait belt protocol was in place to manage how staff utilized Resident #2's gait belt. The plan goes on to identified the following interventions: "Fasten the gait belt around the individual's waist with the buckle placed in front of the individual ... Place one hand on the portion of the gait belt at the front of the individual's waist and place your other hand on the portion of the gait belt at the individual's back Walk to the side and slightly behind the individual." At no time during the evening was staff observed implementing the measures outlined above to manage Resident #2's ambulation from her rolling walker to the dining room table. Interview and record review with the GHPID's qualified intellectual disabilities professional (QIDP) on 1/19/12, at approximately 2:45 p.m., confirmed the staff should have implemented the gait belt protocol as written.	I 229	Staff will receive additional training on gait belt protocol for Client #2 by the Primary Care Nurse. QIDP and Primary Care Nurse will monitor for proper usage.	2/10/12

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FORM APPROVED

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018		
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I 229	Continued From page 9 As of the date of survey, the staff working with Resident #2 failed to properly implement her gait protocol to ensure her health and safety.	I 229		
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 8-1972 (1989 Repl. Vol.). 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 maintain resident records in accordance with requirements of D.C. Law 2-137 (now Title 7, Chapter 13), for four of the four residents of the GHPID. (Residents #1, #2, #3 and #4) The finding includes: § 7-1305.12. Maintenance of records; information considered privileged and confidential; access; contents [Formerly § 6-1972] "Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (9) A summary of family visits and contacts" Cross refer to I002 and Federal Deficiency Report - Citation W153. On 1/18/12, beginning at 10:54 a.m., review of incident reports and corresponding investigation reports revealed that on 8/20/11, at approximately 1:30 p.m., a direct support staff witnessed a driver hit Resident #3 several times on her head while disembarking the facility's van, after	I 292		

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1292	Continued From page 10 returning from a community outing. The facility documented having notified Resident #3's family (mother and sister) of the allegation on 8/22/11. The facility's internal investigation report, dated 9/16/11, revealed that the allegation of abuse had been substantiated. On 1/18/12, at 1:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that she had informed Resident #3's family regarding the results of the internal investigation, and that the allegation of abuse was substantiated. She said this information was shared via telephone conversation with the family. The QIDP indicated that Resident #3's mother and sister were "very involved" in her life. The GHPID said she maintained frequent contacts with the family. The resident's family also telephoned and visited the resident at the GHPID. When asked, the QIDP replied "no," these visits and contacts with the family were not being documented in the resident's record. She further added that none of the four residents' records included a record of family visits and contacts.	1292	 In the future, the family will be formally contacted via email and through phone calls to ensure that they are aware of all incidents. QIDP has developed a formal call log which will document all future communication between family for all incidents. The contact log will document all contact from the QIDP with family and medical guardians regarding each individual. A visitor log will also be utilized to document all visits from medical guardians and family members. These logs will be updated and reviewed weekly by the QIDP for record keeping purposes.	 2/10/12 2/15/12
1372	3519.3 EMERGENCIES Each GHPID shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's	1372	 QIDP will post emergency personnel phone numbers by all telephones in the group home.	 2/28/12 2/28/12

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2536 MYRTLE AVENUE NE WASHINGTON, DC 20018		
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I 372	Continued From page 11 on-duty administrator. The finding includes: Observations on 1/19/12, at 2:50 p.m., revealed there was a list of agency staff posted by the two telephones in the facility. The list included a phone number for an "Emergency Nurse." The list did not, however, include all of the numbers required by this regulation. This deficiency was acknowledged by the qualified intellectual disabilities professional at 2:52 p.m.	I 372		
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... 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 a copy of professional credentials was maintained for each individual providing professional services at the GHPID, for 3 of the 8 consultants (C1, C2 and C4), as required by District of Columbia law,	I 399	Agency's list of emergency contact numbers will reflect that of emergency personnel (police, fire, ems) as well as primary care physicians contact information.	2/17/12

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1399	Continued From page 12 including in the following discipline or area: (1) Speech and Language Therapy. The finding includes: On 1/19/12, beginning at 9:38 a.m., review of the personnel records revealed the GHPID failed to have evidence that the speech language pathologist (C4) under contract had a current license to practice in the District of Columbia. On 1/19/12, at 2:05 p.m., the qualified intellectual disabilities professional acknowledged that there was no evidence of current a professional license for C4 and further indicated that she would bring it to the attention of their human resources director. She confirmed that the consultant had performed an assessment for Resident #1 on 1/18/10. She further confirmed that Resident #1 had a communication program. No additional information was presented on the day before the survey ended later that day at 5:00 p.m.	1399	The current Speech Pathologist has applied for licensure in the District of Columbia; however a licensed speech pathologist will be utilized until licensure is obtained. QIDP will review consultant personnel folders quarterly to ensure that all licenses are valid and up to date, and that all assessments and therapies are administered by a D.C. licensed consultant. The Speech Pathologist has provided a receipt to confirm she has filed an application for licensure in D.C.	2/23/12

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R 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from 1/18/12 through 1/19/12. A sample of two residents was selected from a population of four women with severe intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at two day programs, interviews with staff and residents at the home and at the two day programs, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	R 000		
R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 1 out of 13 direct support staff. [S1]</p> <p>The finding includes:</p> <p>On 1/19/12, at approximately 10:00 a.m., review of the personnel record for S1 revealed that a</p>	R 125		

Health Regulation & Licensing Administration

TITLE _____ (X6) DATE _____

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

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20016		
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R 125	Continued From page 1 District of Columbia background check had been documented on 12/10/07. However, her employment application form, dated 12/17/07, indicated that she was employed in Upper Marlboro, Maryland at the time she completed the application form. There was no evidence that a background check had been obtained in that jurisdiction. On 1/19/12, at 2:05 p.m., the qualified intellectual disabilities professional confirmed the finding and further indicated that she would bring it to the attention of their human resources director. No additional information was presented before the survey ended later that day at 5:00 p.m.	R 125	S1 will obtain an additional background check which will include the District of Columbia and Maryland. HR will continue to ensure that all employees are required to obtain a background check to include all states an employee has worked and lived for the past 7 years.	3/2/12