

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from January 2, 2014 - January 3, 2014. A sample of three clients was selected from a population of five women with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.

The findings of the survey were based on observations, interviews with direct support staff, nursing and administrative staff, as well as a review of clients' medical and habilitation records.

Note: The below are abbreviations that may appear throughout the body of this report.

- Administered as needed - PRN
- Cubic Centimeters - cc's
- Direct Support Professional - DSP
- Health Regulation and Licensing Administration - HRLA
- House Manager - HM
- Group Home for Individuals with Intellectual Disabilities - GHID
- Intermediate Care Facility - ICF
- Individual Support Plan - ISP
- Licensed Practical Nurse - LPN
- Medication Administration Record - MAR
- Physician's Order Sheets - POS
- Primary Care Physician - PCP
- Qualified Intellectual Disabilities Professional - QIDP
- Registered Nurse - RN

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

Each client's active treatment program must be integrated, coordinated and monitored by a

*Received 2/11/14*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
899 North Capitol St., N.E.  
Washington, D.C. 20002

The new PT was out of the country after assessing Client #1 (from late November through early January 2014). The QIDP did not have an opportunity to provide feedback about the existing ambulation protocol until she returned. The PT has been informed that the existing ambulation protocol may not be best suited for Client #1 and is returning to reassess the use of the protocol on...1-25-14 The QIDP will ensure that the PT has all of the needed feedback from staff on the issues with using the existing protocol and will provide opportunities for the PT to observe its use (i.e. the existing protocol techniques). If the PT makes changes in the protocol, the QIDP will arrange an all staff meeting within 7 days of the protocol revisions so that the PT can train all staff to competency...2-7-14

In the future, the QIDP will seek support from alternate PT supports (the PT is a member of an agency support team) if the assigned PT is unavailable to address an acute concern...2-1-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ante K. Moore, Director of Residential Services* TITLE *Director of Residential Services* (X6) DATE *1/24/14*

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.

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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 159

Continued From page 1  
qualified mental retardation professional.

W 159

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the QIDP failed to coordinate services timely (specifically, obtain an updated ambulation protocol from the physical therapist), for one of three clients in the sample. (Client #1)

The finding includes:

On January 2, 2014, at 1:48 p.m., DSP # 1 was observed holding Client #1's hands while they walked together. The staff was walking backwards while the client walked forwards. At 3:59 p.m., the house manager (HM #1) was observed using the same ambulation technique with Client #1. Two minutes later, however, DSP #2 was observed using a different technique. DSP #2 walked in a forward direction; her arms hung down to either side and her hands were slightly behind her. Client #1 walked behind the staff, holding her hands. The client had her face placed up against DSP #2 back.

Earlier on January 2, 2014, at approximately 10:20 a.m., concurrent interview with the QIDP, HM #1 and the Incident Management Coordinator (IMC) revealed that Client #1 was known to hit staff and visitors, often for no apparent reason. She may strike men or women, familiar or unfamiliar, sometimes using enough force to cause significant pain to the person receiving the blow. It was primarily due to her assaultive behavior that facility staff were expected to accompany Client #1 when she ambulated. They further noted that the client's gait also was impaired due to physical disabilities.

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/03/2014
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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)	
W 159	<p>Continued From page 2</p> <p>On January 3, 2014, at 11:25 a.m., an Ambulation Protocol, dated December 12, 2012 (updated August 22, 2013) was reviewed in Client #1's habilitation records. The protocol included: "Allow &lt;client's name&gt;... to ambulate. Guard her on either side. Keep one hand at her pelvis and your other hand at her trunk. Your body should be close to her body without interfering with her movements...If she starts to lose her balance, use your arms and position your body against her body to assist with regaining her balance. Avoid pulling on her upper extremities..."</p> <p>When queried further on January 3, 2014, at 4:50 p.m., both the QIDP and the HM stated that the technique outlined in Client #1's Ambulation Protocol was not suited to the client's needs. They indicated that Client #1 was likely to hit staff if they were to walk to her side. In addition, facility staff had determined that holding the client's hands while they walked together allowed them to redirect the client more quickly and effectively if they sensed that she was about to strike someone. They further explained that the aforementioned information was known for "quite a while" however, neither the QIDP nor the HM had been present when the former PT had assessed the client in December 2012 and August 2013.</p> <p>The QIDP presented a physical therapy (PT) assessment, dated December 11, 2013. The new assessment had been prepared by a new PT. Review of the assessment, however, revealed that it did not assess her ambulation needs. It did however, recommended the continued use of the existing Ambulation Protocol. The QIDP acknowledged this and said that when the team</p>	W 159		

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/03/2014
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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 159	Continued From page 3 discussed the issue at Client #1's recent ISP meeting (December 14, 2013) they asked that the new PT re-evaluate the client and develop an updated protocol.  At the time of the survey, there was no evidence that the QIDP sought timely reassessment of Client #1's ambulation needs and development of an effective protocol.  This is a repeat deficiency. See Federal deficiency report dated February 8, 2013.	W 159		
W 336	483.460(c)(3)(iii) NURSING SERVICES  Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing services failed to ensure nursing quarterly reviews were conducted for three of three clients in the sample. (Clients #1, #2 and #3)  The finding includes:  On January 3, 2014, at 4:20 p.m., review of Client #2's nursing records revealed that she had received a comprehensive, annual physical evaluation by an RN on January 3, 2013. Continued review of the nursing records revealed that RNs had periodically reviewed some of the client's known health risk areas. There was no evidence, however, of comprehensive quarterly	W 336	The DON has mandated that the assigned RN complete comprehensive quarterly assessments for each person supported. The assigned RN will present person-specific formats for completing the quarterly reviews. The formats must at minimum; (1) address the status of all active issues identified on the HCMP; (2) address the status of any acute concerns that developed in the quarter; (3) address the outcomes of all clinical follow up. The RN will provide the DON with an electronic copy of each quarterly review completed for her review and approval. The RN will also maintain a quarterly review schedule for her entire cluster that outlines the review time frames for each person in her caseload. This schedule will be reviewed and approved by the DON...beginning 2-1-14  The DON, QA/RN, assigned QIDP and QA Auditor will monitor compliance routinely...2-1-14	

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014	
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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 336	Continued From page 4 assessments performed by an RN. Review of Client #1's and Client #3's nursing records on January 3, 2014, at 12:35 p.m. and 10:30 a.m., respectively, revealed similar findings.  When asked about this on January 3, 2014, at approximately 6:10 p.m., the Director of Nursing stated that she had identified the need for more thorough quarterly assessments (beyond the current practice of reviewing the clients' known risk areas) and she subsequently had instructed nurses to perform comprehensive quarterly physical examinations of all clients.  At the time of the survey, the facility failed to ensure quarterly nursing assessments were conducted for all clients as required.  This is a repeat deficiency. See Federal deficiency report dated February 8, 2013.	W 336		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW  An individual medication administration record must be maintained for each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication records were accurately maintained, for one of five clients receiving medications. (Client #4)  The finding includes:  On January 2, 2014, at 5:19 p.m., a medication nurse (LPN #1) was observed administering Client #4's medications. At 6:35 p.m., review of Client #4's MARs for January 2014 revealed that	W 365	The medication has been discontinued; however, the Medication Administration LPN did not follow the regimen as outlined on the MARs during this observation. The LPN has received training from the DON and a personnel action...1-15-14 Medication administration will be monitored by the DON, QA/RN, QA Auditor and QIDP to ensure consistency in following the prescribed regimens...2-1-14	

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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 365 Continued From page 5  
LPN #1 documented having administered Menthol 0.25% hydrophor OT ointment to the client's body and hands. Observations earlier that evening, however, had not shown the client being administered the ointment. Review of Client #4's most recent signed POS, dated October 4, 2013 (hand written readmission orders following a hospital stay) failed to show evidence of a current order for that ointment. September 2013 POS did reflect daily use of the ointment prior to the hospitalization.

W 365

When asked about Client #4's Menthol ointment on the next morning, January 3, 2014, beginning at 8:45 a.m., LPN #1 replied "I think it's PRN...supposed to be discontinued." She presented a tube of Menthol 0.25% hydrophor ointment with Client #4's name on the label. She then stated that she had not administered the ointment. When LPN #1 was shown the client's MAR, she acknowledged they were her initials on the MAR indicating she had administered the ointment. She also noted that the MAR did not reflect the ointment as having been changed to "provide as needed" or discontinued altogether. LPN #1 stated that she would seek to clarify the order with the PCP, and the client's MAR would be updated to reflect the outcome of said communications.

W 368 483.460(k)(1) DRUG ADMINISTRATION

W 368

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record

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

PRINTED: 01/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/03/2014
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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-368	<p>Continued From page 6</p> <p>review, the facility failed to ensure that each client's prescribed drugs were administered in accordance with physician's orders, for two of five clients residing in the facility. (Clients #2 and #5)</p> <p>The findings include:</p> <p>I. On January 2, 2014, at 5:31 p.m., a medication nurse (LPN #1) was observed administering Client #2's medications, including Polyethylene glycol (Miralax) powder (17 grams) mixed into apple sauce. At 6:50 p.m., review of Client #2's current POS revealed the physician had ordered the powder to be mixed "in 8 ounces fluid by mouth..." daily for constipation.</p> <p>When asked about Client #2's Miralax on January 3, 2014, at 9:08 a.m., LPN #1 said she routinely mixed it into 60 cc's of apple sauce because Client #2 might not drink her water if she mixed the laxative in with the water. LPN #1 acknowledged that 60 cc's was approximately 2 ounces in volume. Further interview revealed that Client #2 had not shown any difficulties receiving the Miralax mixed with apple sauce and her bowel movements had consistently been regular (verified later that day through review of the client's nursing records). LPN #1 stated that she would seek to clarify the order with the PCP, and the client's POS and MARs would be updated to reflect the outcome of said communications.</p> <p>II. On January 2, 2014, at 5:55 p.m., LPN #1 was observed administering Client #5's medications. At 7:10 p.m., review of Client #5's MARs for January 2014 revealed that LPN #1 documented having administered Enulose 30 cc's. Observations earlier that evening, however, had not shown the client being administered the</p>	W 368	<p>The LPN has been trained to inform the RN if there is a reason to change a strategy for implementing a medication pass. The LPN should not have changed the strategy on her own even though it is routinely successful. The RN will discuss a strategy change with the PCP so that the LPNs have the option to try mixing the Miralax with water or applesauce to ensure that medication administration is successful with 100% consistency. The order will be changed by...2-1-14.</p> <p>The LPN as interviewed on the survey outcomes indicated that the Enulose was given but as indicated by the surveyor, she failed to ensure that the surveyor saw her add the medication to the water. The DON reinforced the LPN on the importance of ensuring that the medication pass is completely transparent during the survey process. The DON and QA/RN as well as the QIDP will periodically observe medication administration to ensure consistency in passing all required medications and transparency in the medication passing process...2-1-14</p>	

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/03/2014
NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 927 65TH 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 368	Continued From page 7 Enulose.  When asked about Client #5's Enulose on January 3, 2014, at 8:48 a.m., LPN #1 said she had poured the Enulose and mixed it in with Client #5's water. She further stated that she had made a "mistake" by not showing the bottle of Enulose to this surveyor during the process.  Observations during the evening medication administration on January 2, 2014 revealed Client #2 and #5 did not receive all medications in accordance with their POS.	W 368			
W 369	483.460(k)(2) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for one of five clients residing in the facility. (Client #6)  The finding includes:  On January 2, 2014, at 5:55 p.m., LPN #1 was observed administering Client #5's medications. At 7:10 p.m., review of Client #5's MARs for January 2014 revealed that LPN #1 documented having administered Enulose 30 cc's. Observations earlier that evening, however, had not shown the client being administered the Enulose.	W 369	The LPN as interviewed on the survey outcomes indicated that the Enulose was given but as indicated by the surveyor, she failed to ensure that the surveyor saw her add the medication to the water. The DON reinforced the LPN on the importance of ensuring that the medication pass is completely transparent during the survey process. The DON and QA/RN as well as the QIDP will periodically observe medication administration to ensure consistency in passing all required medications and transparency in the medication passing process...2-1-14		

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

PRINTED: 01/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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 369	<p>Continued From page 8</p> <p>When asked about Client #5's Enulose on January 3, 2014, at 8:48 a.m., LPN #1 said she had poured the Enulose and mixed it in with Client #5's water. She further stated that she had made a "mistake" by not showing the bottle of Enulose to this surveyor during the process.</p> <p>Observations during the evening medication administration on January 2, 2014 revealed #5 did not receive all medications without error.</p>	W 369		
-------	---	-------	--	--

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1000 INITIAL COMMENTS

A licensure survey was conducted from January 2, 2014 through January 3, 2014. A sample of three residents was selected from a population of five women with varying degrees of intellectual disabilities.

The findings of the survey were based on observations, interviews with direct support staff, nursing and administrative staff, as well as a review of clients' medical and habilitation records.

Note: The below are abbreviations that may appear throughout the body of this report.

- Administered as needed - PRN
- Cubic Centimeters - cc's
- Direct Support Professional - DSP
- Health Regulation and Licensing Administration - HRLA
- House Manager - HM
- Group Home for Individuals with Intellectual Disabilities - GHIID
- Intermediate Care Facility - ICF
- Individual Support Plan - ISP
- Licensed Practical Nurse - LPN
- Medication Administration Record - MAR
- Physician's Order Sheets - POS
- Primary Care Physician - PCP
- Qualified Intellectual Disabilities Professional - QIDP
- Registered Nurse - RN

1071 3503.2 BEDROOMS AND BATHROOMS

Each bed shall be placed at least three feet (3 ft.) from any other bed and at least three feet (3 ft.) from any unprotected radiator.

The existing sleigh beds which prevented proper spacing have been replaced. There is now sufficient space between the beds...1-25-14

Health Regulation & Licensing Administration

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

TITLE

(X6) DATE

*Beth K. Moore, Director of Residential Services* 1/24/14

PRINTED: 01/16/2014  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1071	<p>Continued From page 1</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHID) failed to ensure a distance of at least three feet between resident beds was maintained for two of five residents in the facility. (Residents #2 and #4)</p> <p>The finding includes:</p> <p>Observation on January 3, 2014, at 4:30 p.m., revealed the space between Residents #2 and #4's twin beds appeared to be less than the required three feet (36 inches). The surveyor measured the space between the two beds and determined that it was 31 inches wide. The house manager (HM #1), who was present at the time, stated that this issue had been identified in the previous survey (February 8, 2013) and they had implemented their plan of correction (POC). The POC had entailed making alterations to a closet door to maximize space.</p> <p>On January 3, 2014, at 5:00 p.m., the director of residential services informed surveyors that she thought the issue had been resolved last year.</p> <p>At the time of the survey, there was no evidence that each client's bed in the facility was placed at least three feet from any other bed, as required.</p>	1071		
------	---	------	--	--

1474	<p>3522.5 MEDICATIONS</p> <p>Each GHMRP shall maintain an individual medication administration record for each resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record</p>	1474	<p>The medication has been discontinued; however, the Medication Administration LPN did not follow the regimen as outlined on the MARs during this observation. The LPN has received training from the DON and a personnel action...1-15-14</p> <p>Medication administration will be monitored by the DON, QA/RN, QA Auditor and QIDP to ensure consistency in following the prescribed regimens...2-1-14</p>	
------	---	------	---	--

PRINTED: 01/16/2014  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1474	<p>Continued From page 2</p> <p>review, the facility failed to ensure medication records were accurately maintained, for one of five residents receiving medications. (Resident #4)</p> <p>The finding includes:</p> <p>On January 2, 2014, at 5:19 p.m., a medication nurse (LPN #1) was observed administering Resident #4's medications. At 6:35 p.m., review of Resident #4's MARs for January 2014 revealed that LPN #1 documented having administered Menthol 0.25% hydrophor OT ointment to the resident's body and hands. Observations earlier that evening, however, had not shown the resident being administered the ointment. Review of Resident #4's most recent signed POS, dated October 4, 2013 (hand written readmission orders following a hospital stay) failed to show evidence of a current order for that ointment. September 2013 POS did reflect daily use of the ointment prior to the hospitalization.</p> <p>When asked about Resident #4's Menthol ointment on the next morning, January 3, 2014, beginning at 8:45 a.m., LPN #1 replied "I think it's PRN...supposed to be discontinued." She presented a tube of Menthol 0.25% hydrophor ointment with Resident #4's name on the label. She then stated that she had not administered the ointment. When LPN #1 was shown the resident's MAR, she acknowledged they were her initials on the MAR indicating she had administered the ointment. She also noted that the MAR did not reflect the ointment as having been changed to PRN or discontinued altogether. LPN #1 stated that she would seek to clarify the order with the PCP, and the resident's MAR would be updated to reflect the outcome of said communications.</p>	1474		
------	---	------	--	--

PRINTED: 01/16/2014  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1500

3523.1 RESIDENT'S RIGHTS

1500

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 group home for individuals with intellectual disabilities (GHID) 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) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for two of five residents of the facility. (Residents #2 and #6)

The findings include:

[483.460(k)(2)] The GHID failed to ensure Residents #2's and #6's right to receive medications in accordance with physician's orders, as follows:

1. On January 2, 2014, at 5:31 p.m., a licensed practical nurse (LPN #1) was observed administering Resident #2's medications, including Polyethylene glycol (Miralax) powder (17 grams) mixed into apple sauce. At 6:50 p.m., review of Resident #2's current POS revealed the physician had ordered the powder to be mixed "in 8 ounces fluid by mouth..." daily for constipation.

When asked about Resident #2's Miralax on January 3, 2014, at 9:08 a.m., LPN #1 said she

The LPN has been trained to inform the RN if there is a reason to change a strategy for implementing a medication pass. The LPN should not have changed the strategy on her own even though it is routinely successful. The RN will discuss a strategy change with the PCP so that the LPNs have the option to try mixing the Miralax with water or applesauce to ensure that medication administration is successful with 100% consistency. The order will be changed by...2-1-14.

The LPN as interviewed on the survey outcomes indicated that the Enulose was given but as indicated by the surveyor, she failed to ensure that the surveyor saw her add the medication to the water. The DON reinforced the LPN on the importance of ensuring that the medication pass is completely transparent during the survey process. The DON and QA/RN as well as the QIDP will periodically observe medication administration to ensure consistency in passing all required medications and transparency in the medication passing process...2-1-14

PRINTED: 01/16/2014  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0236	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/03/2014
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 927 55TH 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1500 Continued From page 4 1500

routinely mixed it into 60 cc's of apple sauce because Resident #2 might not drink her water if she mixed the laxative into her water. LPN #1 acknowledged that 60 cc's was approximately 2 ounces in volume. Further interview revealed that Resident #2 had not shown any difficulties receiving the Miralax mixed with apple sauce and her bowel movements had consistently been regular. LPN #1 stated that she would seek to clarify the order with the PCP, and the resident's POS and MARs would be updated to reflect the outcome of said communications.

ii. On January 2, 2014, at 5:55 p.m., LPN #1 was observed administering Resident #5's medications. At 7:10 p.m., review of Resident #5's MARs for January 2014 revealed that LPN #1 documented having administered Enulose 30 cc's. Observations earlier that evening, however, had not shown the resident being administered the Enulose. When asked about Resident #5's Enulose on January 3, 2014, at 8:48 a.m., LPN #1 said she had poured the Enulose and mixed it in with Resident #5's water. She further stated that she had made a "mistake" by not showing the bottle of Enulose to this surveyor during the process.