

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2011
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 TEWKESBURY PL, NW WASHINGTON, DC 20012
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1000 INITIAL COMMENTS

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A licensure survey was conducted from November 1, 2011 through November 3, 2011. A sample of three residents was selected from a population of five men with various intellectual and developmental disabilities.

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

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

Received 11/25/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
800 North Capitol St., N.E.
Washington, D.C. 20002

1090 3504.1 HOUSEKEEPING

1090

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by:
Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner.

The findings include:

Observations during the environmental walk-through and interview with the qualified intellectual disabilities professional (QIDP), and the agency contracted engineer on October 3, 2011, beginning at approximately 1:00 p.m.,

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Arthur Moore, Director of Residential Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
11/21/11

(X6) DATE

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I 090	Continued From page 1 revealed the following: 1. On the front entrance door frame and the side entrance door frame there was chipping and peeling paint. 2. The carpet in the dining room , living room and bedroom #4 was soiled. 3. There were broken floor tiles at the entrance on the first floor landing that could potentially become a trip hazard to residents and staff. 4. There are a number of broken floor tiles in the basement recreational area. 5. In Resident #6's bedroom there were broken and missing floor tiles, and the door frame at the entrance to the bedroom was broken. 6. In Resident #5's bedroom there were missing floor tiles at the front of the bed.	I 090	3504.1 1. The front entrance door will be scrapped and repainted by...November 30, 2011 2. The dining room carpet will be professionally cleaned again by...11-30-11 3. Floor tiles have been replaced...11-21-11 4. Floor tiles will be replaced...11-30-11 5. Floor tiles replaced...11-21-11 6. Floor tiles replaced...11-21-11 The facility manager will audit the physical environment at minimum monthly to discover such issues and report them for follow up. The Assistant to the Director of Residential Services job description has been modified to reflect more attention given to the home environments via monthly audit reports and follow up on issues found...11-1-11
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 one of the eleven	I 206	

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I 206	Continued From page 2 staff (Staff #1), and two of four consultants, the physical therapist and psychologist had current health certificates. The findings include: On November 3, 2011, beginning at approximately 2:30 p.m., review of the personnel records revealed the GHPID failed to have evidence of current health certificates for one staff, and two of the four consultants. The staff confirmed that the aforementioned personnel were without current health certificates in their personnel files.	I 206	3509.6 The staff member without a current health certificate was taken off the active schedule pending receipt of a valid health certificate...11-30-11 The current health certificate for the psychologist is attached to the responses...11-1-11 The PT has been notified to provide a current health certificate by...11-30-11 MTS HR audited the personnel records comprehensively and sent notices to all relevant consultants regarding specific deficiencies in their file. Follow is required by...11-30-11. Monthly tracking and notifications will be implemented via HR beginning...11-30-11	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure a continuous, ongoing in-service training program to address the needs, for one of three residents in the sample. (Resident #3) The finding includes: On November 1, 2011, at approximately 3:59 p.m., Resident #3 was observed entering the facility with the direct care staff entering behind him with a roller walker which was placed in front of the resident as he walked to his bedroom. At 4:07 p.m., the direct care staff was heard telling the resident that he needed to put on his gait belt. Interview with the direct care staff on November 3, 2011, revealed the resident only wears the gait	I 222		

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I 222	<p>Continued From page 3</p> <p>belt when he is in the facility.</p> <p>Review of the resident's habilitation record on November 3, 2011, at approximately 6:15 p.m. revealed an "ambulation protocol" dated August 8, 2011, indicating that the resident "should wear the gait belt during the day while he is mobile." It should be noted that on November 3, 2011, at approximately 4:20 p.m., Resident #3 was observed leaving the facility for a community outing and was not wearing his gait belt. Further review of the record revealed a physical therapy (PT) note dated August 8, 2011, which indicated that training was provided to the staff on "gait belt, ambulation, fall prevention, stair climbing, and transfers using handrails on the toilet.</p> <p>At the time of the survey, the facility failed to ensure the direct care staff implemented Resident #3's ambulation protocol as recommended.</p>	I 222	<p>PT retrained staff on the use of the gait belt on...11-4-11 The QDDP will monitor implementation at minimum twice weekly during active treatment hours and provide on-the-spot training as needed...11-1-11</p> <p>ETE</p>
I 404	<p>3520.6 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all staff received instructions to ensure correct implementation of physical therapy recommendations for Resident #3.</p>	I 404	<p>ETE</p>

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1404 Continued From page 4

1404

The finding includes:

On November 1, 2011, at approximately 3:59 p.m., Resident #3 was observed entering the facility. Further observation revealed a direct care staff entering the facility behind him. The staff was observed to carry a roller walker and placed it in front of Resident #3 as he continued to walk to his bedroom. At 4:07 p.m., the direct care staff was heard telling the resident that he needed to put on his gait belt. Interview with the direct care staff on November 3, 2011, revealed the resident only wears the gait belt when he is in the facility.

Review of the resident's habilitation record on November 3, 2011, at approximately 6:15 p.m. revealed Resident #3 had an ambulation protocol dated August 8, 2011. According to the protocol, the resident "should wear the gait belt during the day while he is mobile."

Interview with the qualified intellectual developmental professional (QIDP) on November 3, 2011, at approximately 6:30 p.m. revealed Resident #3 was not wearing the gait belt at the day program because the day program staff had not been trained.

At the time of the survey, the facility failed to ensure that all staff received instructions to ensure correct implementation of physical therapy recommendations for Resident #3.

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

3520.6

The PT will conduct a training session at the day program on...11-25-11

2011
11-03

2011
11-03

2011
11-03

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I 500 Continued From page 5

I 500

laws.

This Statute is not met as evidenced by:
Based on observations, the group home for persons with intellectually disabilities (GHPID) 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 other District and federal laws that govern the care and rights of persons with intellectually disabilities, for six of six residents. (Residents #1, #2, #3, #4, #5 and #6)

The findings includes:

On November 3, 2011, at approximately 4:30 p.m., the residents were being loaded in the van preparing to go on an outing. Prior to their leaving the facility, the van was checked for cleanliness and safety. It was noticed that five of the six residents did not have seat belts fastened. The QDIP was informed him that the residents would not be able to leave the facility without wearing seat belts. The QDIP made several phone calls to ascertain availability of another van that would accommodate the residents and found there were none available. The staff and the driver assisted the surveyor in adjusting the seat belts so the residents could be properly secured. The seat belts were repaired and all aboard the van were in seat belts as they left the facility.

3523.1

The QDDP retrained staff on securing individuals in the vehicle by properly using the seat belts and to report repair issues immediately...11-4-11
The facility manager will monitor compliance bi-weekly at minimum via routine observations...11-30-11