

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from 9/23/2010 through 9/24/2010. A sample of two clients was selected from a population of four men with profound cognitive and intellectual disabilities. In addition, a focused review was conducted of another (third) client's dietary food texture orders. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of health care services and active treatment, the process was extended on 9/24/2010 to review the facility's level of compliance in the Conditions of Participation (CoP) for Health Care Services and Active Treatment.

receive 10/15/10

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

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 qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health and safety of three of the four clients residing in the facility. [Clients #1, #2 and #3]

The findings include:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Caitano A. Reese</i>	TITLE <i>Program Director</i>	(X6) DATE <i>10-15-10</i>
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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 159 Continued From page 1

W 159

1. [Cross Reference W189 and W193] The QMRP failed to ensure all staff received effective training on the implementation of Client #3's food texture requirements, Client #1's behavior support plan and proper documentation of Client #1's bowel movements.

1. Staff will receive training on Client #3 food texture requirements, Client #1 BSP and proper documentation for his bowel movement charts.

10/29/10

2. [Cross Reference W194] The QMRP failed to ensure all staff demonstrated competency in implementing a client's food texture requirements and implementation of a behavior support plan.

2. The nutritionist will provide training on client's food texture.

10/29/10

3. [Cross Reference W2525] The QMRP failed to ensure that staff documented all incidents of Client #1's observed maladaptive behaviors.

3. The psychologist will provide training on-going training to all staff on Client #1 BSP. The QMRP and House Manager will review data on a daily basis to ensure staff are accurately documenting behaviors. Failure to properly document all behaviors will result in disciplinary action.

10/29/10

4. [Cross Reference W436] The QMRP failed to ensure all clients received their recommended adaptive equipment.

4. QMRP and Nursing Staff will implement recommendations for adaptive equipment.

10/29/10

4. [Cross Reference W474] The QMRP failed to ensure all clients received their meals in the prescribed texture.

5. Daily meal observations will be conducted by the QMRP/ Residential Manager to ensure that all individuals receive the prescribed texture.

10/29/10

5. The facility's QMRP failed to ensure the ambulation protocol was available and presented to all staff to ensure consistent implementation while assisting Client #2 while ambulating, as follows:

6. The QMRP and House Manager will ensure Client #2 receives their recommended adaptive equipment as well as ensures an ambulation protocol is in place. All staff will receive training on the current protocol as well as on-going training for any changes.

10/29/10

Observation on 9/23/2010, at approximately 12:15 p.m., revealed Client #2 was wearing a loosely secured gait belt and a soft padded helmet. The helmet appeared to be properly fitted and the gait belt was loosely secured around his waist. During the observation, Client #2's 1-on-1 nursing staff (provided by the facility) used his left hand to hold the right side of Client #2's gait belt as he assisted him to ambulate

Gautam A. Reese - Program Director 10/26/10

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W 159 Continued From page 2
around the facility. On other occasions, he was observed holding to the back of Client #2's gait belt as he walked behind him. Later on the same day at approximately 4:20 p.m., Client #2 returned home from his day program. Upon exiting the van, the attending nurse and one of the van staff each grabbed under Client #2's armpits and assisted him up the stairs to the front door of the facility. The attending nurse was then observed to continue the hold under Client #2's left arm and assisted him up the stairs to his bedroom.

W 159

Record review on 9/24/2010 at 12:08 p.m. revealed. Client #2's Physical Therapy assessment dated 08/03/2009 recommended that the facility continue the ambulation protocol. Further record review and interview with the QMRP on 9/24/2010, at approximately 3:00 p.m., revealed there was no documented evidence an ambulation protocol was drafted and on file for review. The QMRP also checked Client #2's habilitation records and confirmed that document was not on file.

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189

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.

Cross reference W159 #2, #5

10/29/10

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all staff received training on the implementation of a client's food texture requirement and behavior support plan, for two of the four clients residing in the facility. [Clients #1 and #3]

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W 189 Continued From page 3

W 189

The findings include:

1. [Cross Reference W193] Record review on 9/24/2010 at approximately 2:55 p.m. revealed only five (5) out of the facility's ten (10) currently employed staff received training on Client #1's behavior support plan (BSP). The training was held on 2/26/2010. In addition, there was no evidence presented or on file at the time of survey to substantiate that any of the currently employed staff received training on how to implement "touch control" in managing Client #1's maladaptive behaviors.

Interview with the facility's house manager (HM) on 9/24/2010, at approximately 2:58 p.m., confirmed there were no other BSP trainings held other than the 2/26/2010 training. The HM further confirmed what was documented on the 2/26/2010 BSP training was true and a factual representation of the staff that attended the training.

The facility failed to ensure all staff received training on Client #1's BSP.

2. [Cross Reference W194] Record review on 9/24/2010, at approximately 2:45 p.m. revealed there was no documented evidence that any of the facility's ten (10) staff received training on Client #3's food texture requirements dating back to 9/1/2009.

Interview with the facility's house manager (HM) on 9/24/2010 at approximately 2:50 p.m. confirmed none of the currently employed staff (10 staff) had received training on Client #3's modified food texture requirements. In addition, the HM also confirmed there were no additional

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

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W 189 Continued From page 4 staff training documents on hand to review.	W 189	Cross reference W159 #1	10/29/10
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The facility failed to ensure all staff received training on Client #3's modified food texture requirements to meet his developmental needs.

3. The facility failed to ensure that the direct support staff received training to ensure consistent documentation of Client #1's bowel movements, as follows:

[Cross Reference W331.3] On 9/23/2010, beginning at 2:54 p.m., review of Client #1's bowel movement (BM) charts revealed that direct support staff on each shift were instructed to enter a zero if he had no BM during their shift or use a symbol listed in the legend below the chart to document and describe every BM. [Example: H = Hard Stool (small rocks)] Continued review of the BM charts revealed numerous gaps where staff failed to provide data from their shift. Failure to document BMs during the past 3 months was noted on each of the three shifts.

On 9/24/2010, at approximately 12:35 p.m., the RN stated that she had provided training to staff on documenting clients' BMs on the BM chart. The RN agreed to seek training records for direct support staff and to contact the Director of Nursing to request evidence of training received by their nursing staff within the past 6 months. Review of staff in-service training records a short time later, beginning at approximately 2:55 p.m., failed to show evidence that the facility's nine (9) direct support staff and the house manager had received training on proper documentation of Client #1's BMs. No additional information was provided for review before the survey ended later that afternoon.

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W 193 483.430(e)(3) STAFF TRAINING PROGRAM

W 193

Cross reference W159 #3

10/29/10

Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure staff accurately and consistently implemented a client's behavior management plan for one of two sampled clients. [Client #1]

The findings include:

1. On 9/23/2010, at approximately 5:25 p.m., Client #1 was observed standing in the kitchen. A direct care staff walked over to him and asked him to set the dinner table. He hesitated in his response and remained standing in the kitchen. Approximately, two minutes later, Client #1 became very agitated and began to hit himself on the face and vocalize loudly. During this outburst, he attempted to hit the direct care staff that made the request of him to set the table, but she avoided him and walked away. With clinched fists, he entered the dining area and stood next to his chair at the dinner table. The direct care staff informed the house manager (HM) that she had asked Client #1 to set the table and that he became agitated at the request. About a minute passed as Client #1 sat at the dinner table when he again began to hit himself on the side of his head/face and began vocalizing loudly.

A short period of quiet passed (about three minutes) before Client #1 again became very agitated and got up from the table and approached the HM. He made three attempts to

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W 193	Continued From page 6	W 193	Cross reference W159 #2, #3	10/29/10
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hit her, but the HM grabbed his hands with an open palm to prevent herself from being hit. Once the HM grabbed his hands, he lowered himself to the floor and laid there face down. Both of his fists were clinched as he lay on the dining room floor and he continued to vocalize loudly and also pounded on the floor. A minute later the HM took Client #1 by his hands and led him to his seat at the dining table. Client #1 remained agitated, with no additional outbursts, until dinner was served.

Record review on 9/24/2010, at approximately 12:05 p.m., revealed Client #1's Behavior Support Plan (BSP), dated 10/14/2009, identified the following interventions to address his targeted behaviors:

a. "Offer him a formal choice once each day. The choice can be between two objects, two rewards, two activities, etc. Or the choice can involve the order of which activities or tasks to do first and which to do second, etc. Reward the fact that he made a choice using descriptive feedback."

b. "Use touch control if the screaming self abusive or hitting others behaviors continue or increase. Staff should physically redirect him to another activity, when verbal redirection does not work, staff may have to use the appropriate touch control technique to gently and quickly point him or move him to another activity. Staff may have to physically prompt him to start doing the correct activity. Only staff who have been trained in these touch control procedures and techniques should use this intervention."

c. "For example, if he is continuing to try to hit at someone, staff may have to physically take him

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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--------------------	--	---------------	---	----------------------

W 193 Continued From page 7
by the elbow and help him walk into another room and guide him to a chair. This is not enough. Staff should attempt to get him involved in some other distracting activity."

W 193

Cross reference W159 #3

10/29/10

d. "Create a "safety zone" if the aggression to others continue to escalate and he is disrupting the entire situation staff should either get him into another area or room or remove others from the area or room he is in."

Interview with the facility's qualified mental retardation professional (QMRP) and HM on 9/24/2010, at approximately 12:30 p.m., confirmed the facility's staff failed to offer him "two choices" from the onset when he was initially asked to set the table. Further dialogue with the QMRP and the HM revealed the facility's staff also failed to physically redirect him to another activity, did not take him by the elbow into another room, and never established a "safety zone" for him in their effort to address his agitation and aggression. Client #1 was allowed to remain in the dining room the entire period he was agitated and was physically aggressive towards staff.

The facility failed to demonstrate competency and accurate implementation of Client #1's behavior support plan to address his behavioral outburst and maladaptive behaviors.

2. [Cross Reference W252] A different team of staff had been observed working with Client #1 earlier that day (morning of 9/23/2010). Those staff failed to demonstrate competency in implementing his behavior support plan (i.e. documenting all incidents of targeted maladaptive behavior). Signature sheets for a behavior management training provided on 2/26/2010

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 193 Continued From page 8
documented that the two staff on duty at the time of Client #1's morning behavioral outburst (screaming, hitting self and hitting Client #3) had been in attendance on 2/26/2010.

W 193

Cross reference W159 #3

10/29/10

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

All staff will be trained on all individual's IPP goals. Management team will review IPP documentation weekly and staff will receive ongoing training on documentation for all IPP goals.

10/29/10

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure the accurate implementation of program plans, for two of the four clients residing in the facility. [Clients #1 and #3]

The findings include:

1. [Cross Reference W249.1] Staff working with Client #1 on the morning of 9/23/2010 failed to demonstrate competency in implementing the client's training program for learning to unbuckle his belt.
2. [Cross Reference W474] The facility's staff failed to demonstrate the skill and competency necessary to ensure Client #3 received all his meals in the texture prescribed to meet his developmental needs, as follows:

Observation on 9/23/2010, at approximately 5:00 p.m., revealed staff served Client #3 his meal in a chopped texture, but failed to ensure the meal was served "mechanically soft" as prescribed by the primary care physician (PCP). Record review on 9/24/2010 at approximately 10:15 a.m.

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--------------------	--	---------------	---	----------------------

W 194	Continued From page 9 confirmed Client #3's current physician's orders (9/2010) prescribed he receive a "mechanically soft, chopped" textured diet.	W 194	Cross reference W159 #1	10/29/10
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Interview with the facility's qualified mental retardation professional on 9/23/2010 at approximately 5:10 p.m. confirmed staff should have provided Client #3 with a "mechanically soft" textured meal as prescribed by the PCP.

W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249	Cross reference W194	10/29/10
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As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement training programs and behavior support plans as recommended by the interdisciplinary team, for one of the two sampled clients. [Client #1]

The findings include:

1. On 9/23/2010, at approximately 7:34 a.m., Client #1 (who is non-verbal) walked over to Staff #1 and stood in front of him. The staff reached for the client's belt while stating that this was the client's means of informing him that he needed to use the bathroom and the client was unable to undo the belt. After the staff unfastened the belt, the client went upstairs to use the bathroom. On

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<p>W 249 Continued From page 10 9/24/2010, at 3:59 p.m., review of Client #1's Individual Support Plan, dated 9/25/2009, revealed that he had a training program for him to learn to fasten and unfasten his belt. The plan stated that staff should provide "verbal prompts" and encourage him to unbuckle his belt. Observations revealed that staff working with him on the morning of 9/23/2010 failed to implement his program when the opportunity presented itself.</p> <p>2. [Cross Reference W193.1] Facility staff failed to consistently implement Client #1's BSP. On the evening of 9/23/2010, Client #1 was observed hitting himself on the face and vocalizing loudly. He also attempted to hit a direct support staff. He repeated the behaviors several times until dinner was served.</p> <p>Record review on 9/24/2010, at approximately 12:05 p.m., revealed Client #1's Behavior Support Plan (BSP), dated 10/14/2009, revealed that staff should "Offer him a formal choice...physically redirect him to another activity...create a 'safety zone' if the aggression to others continue to escalate and he is disrupting the entire situation staff should either get him into another area or room or remove others from the area or room he is in."</p> <p>Observations, however, had revealed that staff failed to offer Client #1 "two choices" from the onset, failed to physically redirect him to another activity, did not take him by the elbow into another room, and never established a "safety zone" for him in their effort to address his agitation and aggression. Client #1 was allowed to remain in the dining room the entire period he was agitated and was physically aggressive towards staff.</p>	W 249	<div data-bbox="893 483 1323 546">Cross reference W194</div> <div data-bbox="893 819 1323 882">Cross reference W159 #2</div>	<div data-bbox="1339 483 1469 546">10/29/10</div> <div data-bbox="1339 819 1469 882">10/29/10</div>
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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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 252 483.440(e)(1) PROGRAM DOCUMENTATION

W 252

Cross reference W159 #3

10/29/10

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 all behavior data in accordance with the behavior support plan (BSP), for one of the two sampled clients. (Client #1)

The finding includes:

On 9/23/2010, at 8:06 a.m., Client #1 started shrieking loudly while seated next to Client #3 in the living room. Client #1 immediately turned to his peer and began striking him on his arm and shoulder. After a few short blows, the client began striking himself on his legs and he then stood up, still screaming. The behavioral outbursts lasted no more than 1 minute, in total. At the outset, Staff #2 responded by calling the client's name. The client quieted and immediately left the living room. Staff #1 stated that the client had been displaying similar behavioral outbursts for the past 3 days and would stay home from day program that day. [Note: The two staff present had been working overnight (12:00 a.m. - 8:00 a.m. shift). Staff #2 stated that he was staying for the next shift (8:00 a.m. - 4:00 p.m.).]

Later that day (9/23/2010), at 1:38 p.m., the house manager asked Staff #2 whether Client #1 had displayed any behaviors during his shift; he replied no." At approximately 5:30 p.m., review of

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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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 252	<p>Continued From page 12</p> <p>Client #1's BSP, dated 10/14/2009, confirmed that screaming, self abuse and hitting others were his primary targeted maladaptive behaviors. The BSP also instructed staff to document each of the behaviors "on the data sheets...in the IPP training book...At the end of the shift, one assigned staff person should determine, by asking other staff, the total frequencies of <client's name> behaviors." On 9/24/2010, at approximately 2:00 p.m., review of the client's behavior data sheets in the IPP training book revealed staff had entered "0" behaviors for the 12:00 a.m. - 8:00 a.m. shift and left blank the spaces for recording each of the three targeted behaviors.</p>	W 252	Cross reference W159 #3	10/29/10
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W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p>	W 331	The nursing staff will receive additional training on physical assessment and documentation of findings.	11/2/10
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This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure clients received nursing services according to their needs, for two of the four clients residing in the facility. [Clients #1 and #3]

The findings include:

1. The facility's nursing staff failed to ensure that Client #1 received a timely medical assessment, as follows:

On 9/23/2010, at approximately 11:50 a.m., Client #1's day program activities coordinator stated that the client had hit himself and others while at the day program on 9/20/2010 and 9/21/2010. He had worked with the client since 2001 and he had only seen the client become assaultive when he

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5510 FIRST STREET NW WASHINGTON, DC 20011
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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 331 Continued From page 13

was "impacted." He said that was the client's way to express pain or discomfort. The client stayed home on 9/22/2010, after the home agreed on 9/21/2010 to have him evaluated. [Note: The client returned to day program on 9/23/2010 with no communication received from the home documenting a physical examination.] Review of Client #1's behavior support plan (BSP) dated 10/6/2009, confirmed "constipation" was the first antecedent listed for targeted behaviors of physical aggression towards others and self-injurious behaviors.

On 9/23/2010, at 3:11 p.m., review of Client #1's primary care physician (PCP) notes revealed the most recent entry was dated 7/30/2010. The house manager (HM) stated that the client had an appointment scheduled with the PCP on the next day, 9/24/2010. Subsequent review of the client's Nurse's Progress Notes revealed entries dated 9/21/2010 at 6 p.m., 9/22/2010 at 7:30 a.m. and 9/23/2010. None of those three entries indicated that a nurse had assessed the client's abdomen and bowels during the three days. The above-cited nurse progress notes did reflect reviews of his BM habits on those dates.

The client was taken to a hospital emergency room (ER) on the evening of 9/23/2010 due to "blood in the urine." The ER discharge report stated that lab testing failed to show blood in the urine. Further review of the ER discharge papers revealed no indication that any diagnostic procedures other than labs/blood in urine had been performed at the hospital.

An entry made by the RN on 9/24/2010 at 7:40 a.m. revealed that "individual in no distress" and she had taken his vital signs. The entry, however,

W 331

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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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 331 Continued From page 14 W 331

did not suggest an assessment of the client's abdomen was performed.

Client #1 was taken to the PCP's office for evaluation on 9/24/2010, at approximately 3:30 p.m., which was 3 days after the day program expressed concerns that his assaultive behaviors might be due to physical discomfort.

It should be noted that staff had documented BMs on the evening shift of 9/18/2010, evening shift of 9/20/2010, evening shift of 9/21/2010, evening shift of 9/22/2010 as well as the morning shifts on 9/23/2010 and 9/24/2010. Nursing staff, therefore, referred to those BMs as evidence that Client #1 was not impacted.

2. The facility's nursing staff failed to ensure that Client #1 consistently received stool softener as needed (PRN), in accordance with his physician's orders (POs), as follows:

a. [Cross Reference W368.3] On 9/23/2010, Client #1's day program activities coordinator expressed concern re: the client's bowel movements and the potential for fecal impaction. Review of Client #1's 9/2010 physician's orders (POs) revealed that since 1/24/1994, he was to receive "Milk of Magnesia 400 mg/5 ml oral suspension, give 45 cc by mouth every 3rd day as needed for constipation if no BM." On 9/23/2010, beginning at 2:54 p.m., review of Client #1's MARs along with a review of the client's Bowel Movement (BM) charts revealed that he had gone without a documented BM on 7/22/2010, 7/23/2010 and 7/24/2010 without receiving the PRN Milk of Magnesia (MOM). The BM chart for 9/2010 showed no documented BM on 9/6/2010, 9/7/2010 and 9/8/2010. A nurse documented

The facility's nursing staff will receive additional training to monitor Bowel Movement Charts and administer prescribed medication as ordered.

10/24/10

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5810 FIRST STREET NW WASHINGTON, DC 20011
--	---

(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 331 Continued From page 15
having administered MOM at 7 p.m. on 9/9/2010 (the 4th day), which was not in accordance with the POs.

W 331

b. On 9/24/2010, at approximately 12:57 p.m., interview with the RN revealed that the evening medication nurse had been instructed to review Client #1's BM chart every 3 days and if there had been no BM, the nurse should administer the MOM, as needed. At approximately 3:20 p.m., review of the client's 9/2010 MAR revealed that the exact dates for said review by the evening nurse had been designated on the MAR every 3 days, beginning on 9/3/2010. The evening nurse documented having reviewed the client's BM chart on 9/3/10 but missed a review on 9/6/2010. The nurse documented a review on 9/9/2010 and 9/12/2010 but then missed a review on 9/15/2010. The evening nurse(s) failed to document a review of Client #1's BM chart every 3 days as instructed.

The facility's nursing staff will be trained on monitoring Bowel Movement and any other health related information.

11/2/10

3. The facility's nursing staff failed to transcribe medication orders, as follows:

[Cross Reference W369] On 9/23/2010, a nurse administered Client #3's Levothyroxine Sodium (Synthroid) 50 mcg after he had eaten breakfast. The nurse said the client's Synthroid order had been changed approximately 2 months earlier. He further stated the orders were to administer the Synthroid 30 minutes before his other medications. When asked if it was to be administered before food, the nurse replied "yes, this helps with absorption." Review of Client #3's Medication Administration Record (MAR) for 8/2010 revealed a handwritten change in the order to "30 minutes prior to breakfast" (previously had been "every morning") and the

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

PRINTED: 10/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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W 331 Continued From page 16

W 331

designated time had been changed from 7:00 a.m. (previously had been 8:00 a.m.). However, review of the client's POs from 7/2010, 8/2010 and 9/2010 failed to show evidence of the change in his orders. In addition, the 9/2010 MAR did not reflect a change to how the order was written; it still included only the typed order "every day" as previously written on 7/2010 and earlier.

The facility's nursing staff will ensure all telephone orders are signed by the PCP in a timely manner. The facility's nursing staff will also notify the pharmacy and new orders to be included in the individual's physician order sheets.

10/29/10

On 9/24/2010, at approximately 1:15 p.m., interview with the RN revealed that she had taken the order by telephone and she had changed Client #3's 8/2010 MAR to read "30 minutes prior to breakfast." Upon request, the RN was unable to locate a corresponding physician's order. At approximately 2:20 p.m., the RN was asked again whether she could recall the approximate date that she had received the telephone order. The RN presented a handwritten order that was signed that day (9/24/2010) by the PCP. The order read "30 minutes before breakfast." The order, however, had the date 8/1/2010 written next to it, with no indication that it was a late entry (by almost 2 months).

5. The facility's nursing staff failed to ensure that all medications listed on Client #3's physician's orders were available "as needed."

On 9/23/2010, at 8:59 a.m., while verifying the morning medication pass observations, Client #3's POs included "ProAir (Albuterol) HFA 90 mcg AER w/Adap Inhale 2 puffs every 6 hours as needed." The POs indicated that the Albuterol was first ordered on 4/4/2008; however, there was no reason given for this PRN medication. At 9:03 a.m., the medication nurse looked through the medication cabinet twice and stated that there was no Albuterol available. He suggested that it

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

PRINTED: 10/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
--	---

(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 331 Continued From page 17

W 331

may have been discontinued; however, we did not find an order to discontinue the medication. At approximately 10:55 a.m., the recently-hired qualified mental retardation professional (QMRP) and the HM indicated they were not aware of any reason why Client #3 might need to use Albuterol. The QMRP immediately presented a Medical Assessment dated 11/27/2009, and upon its review, stated that she saw no indications for the PRN medication.

The nursing staff will receive training on reviewing physician's order sheet, telephone orders and ensuring all prescribed medications are available. The primary nurse of this facility will be requested to provide written documentation and that MAR's and POS's are reviewed and updated on a weekly basis.

11/2/10

On 9/24/2010, at approximately 1:00 p.m., the recently-hired RN stated that Albuterol was typically prescribed for treating asthma. She indicated that she was previously unaware that Albuterol PRN was prescribed PRN on Client #3's POs. She replied "no" when asked if the medication nurse had informed her of his search for it on the previous day. At approximately 2:20 p.m., the RN indicated that the PCP had just informed her the Albuterol had been needed only back at the time it was ordered in 2008. She then presented a handwritten order to discontinue the Albuterol, signed that day by the PCP.

There was no evidence that the facility's nurses and medical team reconciled physician's orders with the medications-on-hand to ensure that medications prescribed for PRN use readily available if and when needed by the client.

W 340 483.460(c)(5)(i) NURSING SERVICES

W 340

Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
--	--

(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 340 Continued From page 18	W 340	Cross reference W159 #1	10/29/10
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This STANDARD is not met as evidenced by:
Based on interview and record review, the facility's nursing staff failed to provide evidence that staff had been trained to consistently document bowel movements, for one of two clients in the sample (Client #1).

The finding includes:

The facility's nursing staff failed to ensure that direct support staff consistently documented Client #1's BM's, as follows:

The direct support staff will receive additional training on monitoring and recording bowel movements. The nursing staff will document on the Medication Administration Record that they have reviewed the BM chart.

10/29/10

As noted above, Client #1's POs dated 9/2010, revealed "chronic constipation" as an ongoing diagnosis. He received Miralax and prune juice daily. The POs also included "Milk of Magnesia 400 mg/5 ml oral suspension, give 45 cc by mouth every 3rd day as needed for constipation if no BM." On 9/23/2010, beginning at 2:54 p.m., review of the client's BM charts revealed that direct support staff on each shift were instructed to enter a zero if he had no BM during their shift or use a symbol listed in the legend below the chart to document and describe every BM. [Example: H = Hard Stool (small rocks)] Continued review of the BM charts revealed numerous gaps where staff failed to provide data from their shift. Failure to document BMs during the past 3 months was noted on each of the three shifts, as follows:

a. 12 a.m. - 8 a.m. shift - staff failed to make entries on 7/1/2010, 7/26/2010, 8/1/2010, 8/2/2010, 8/5/2010 and 8/30/2010;

b. 8 a.m. - 4 p.m. shift - there was no data on his BM chart on 7/2/2010, 7/10/2010, 7/11/2010.

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

PRINTED: 10/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

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W 340 Continued From page 19
7/19/2010, 7/22/2010, 7/23/2010, 8/6/2010,
8/31/2010, 9/1/2010, 9/14/2010 and 9/23/2010;
and,

c. 4 p.m. - 12 a.m. shift - staff failed to make
entries on 7/31/2010, 8/1/2010, 8/6/2010,
8/14/2010 and 8/15/2010.

W 340

On 9/24/2010, at approximately 12:35 p.m., the RN stated that she had provided training to staff on documenting clients' BMs on the BM chart. The RN agreed to seek training records for direct support staff and to contact the Director of Nursing to request evidence of training received by their nursing staff within the past 6 months. Review of staff in-service training records a short time later, beginning at approximately 2:55 p.m., failed to show evidence that the facility's nine (9) direct support staff and the house manager had received training on proper documentation of Client #1's BMs. No additional information was provided for review before the survey ended later that afternoon.

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, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for three of the four clients residing in the facility. (Clients #1, #3 and #4)

The findings include:

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5810 FIRST STREET NW WASHINGTON, DC 20011
---	---

(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 20 W 368

1. [Cross Reference W369] On 9/23/2010, Client #3 was administered Levothyroxine Sodium (Synthroid) 50 mcg after he had eaten breakfast. Interviews and review of physician's orders (POs), however, revealed that the medication should be administered "30 minutes prior to breakfast" to enhance absorption.

2. On 9/23/2010, Client #4 was observed receiving his medications between 9:11 a.m. - 9:26 a.m. At 9:27 a.m., the medication nurse documented the following on the client's Medication Administration Record (MAR): "Hypotears 1% one drop in each eye not available this a.m." After the medication nurse finished a telephone conversation with the Director of Nursing, at 9:37 a.m., he looked again in the medication cabinet and declared "found it...it was behind" other medications. By then, however, Client #4 had left the facility; therefore, he was not administered the Hypotears (for dry eyes) in accordance with his POs.

3. Facility nurses failed to ensure that Client #1 consistently received stool softener as needed (PRN) for constipation, in accordance with his POs, as follows:

On 9/23/2010, at approximately 11:50 a.m., Client #1's day program activities coordinator stated that the client had hit himself and others while at the day program on 9/20/2010 and 9/21/2010. The client had stayed home on 9/22/2010, after the home agreed to have him evaluated for possible impaction. Review of Client #1's behavior support plan dated 10/6/2009, revealed that "constipation" was an antecedent listed for the targeted behaviors of physical aggression towards others and self-injurious behaviors.

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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W 368 Continued From page 21

W 368

Cross reference W331

11/2/10

On 9/23/2010, Client #3's medical records were reviewed upon return to the facility, beginning at 1:40 p.m. His Medical Assessment, dated 8/27/2010 and his POs 9/2010 revealed "chronic constipation" as an ongoing diagnosis, for which he received Miralax 17 grams dissolved in water daily (since 12/8/2009) and prune juice 6 oz by mouth twice daily (since 1/24/1994). The POs showed that since 1/24/1994, he was to receive "Milk of Magnesia 400 mg/5 ml oral suspension, give 45 cc by mouth every 3rd day as needed for constipation if no BM." Beginning at 2:54 p.m., review of Client #1's MARs along with a review of the client's Bowel Movement (BM) charts revealed that he had gone without a documented BM on 7/22/2010, 7/23/2010 and 7/24/2010 without receiving the PRN Milk of Magnesia (MOM). The BM chart for 9/2010 showed no documented BM on 9/6/2010, 9/7/2010 and 9/8/2010. A nurse documented having administered MOM at 7 p.m. on 9/9/2010, which was not in accordance with the POs.

W 369 483.460(k)(2) DRUG ADMINISTRATION

W 369

Cross reference W331

11/2/10

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, staff interview 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]

The finding includes:

On 9/23/2010, the survey started at 6:46 a.m., at

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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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 Continued From page 22

W 369

which time staff stated that Client #3 had already finished his breakfast and cleared his place setting. At 7:10 a.m., Staff #1 turned to his colleague and stated that he just remembered having been told that "starting today," they were to 'hold' Client #3's breakfast until after he received a pill. The medication was to be administered 30 minutes before his other medications and breakfast. Staff #1 further explained that a nurse that provides Client #2 1:1 care was to administer the pill at 7:00 a.m. and a medication nurse would arrive at 7:30 a.m. to administer other medications to Client #3 and his peers.

At 7:20 a.m., Client #2's 1:1 nurse brought him downstairs and administered Client #3's Levothyroxine Sodium (Synthroid) 50 mcg. The nurse said Client #3 received the medication to treat hypothyroidism. Approximately 2 months earlier, the client's order had been changed to administer the Synthroid 30 minutes before the other medications. When asked if it was to be administered before food, he replied "yes, this helps with absorption." Review of Client #3's Medication Administration Record (MAR) for 8/2010 revealed a hand written change in the order to "30 minutes prior to breakfast" and the designated time had been changed from 7:00 a.m. (had been 8:00 a.m., previously).

It should be noted that on 9/24/2010, at approximately 1:20 p.m., interview with the QMRP revealed that the clients ate breakfast at "approximately the same time" every morning. Breakfast had been served that morning prior to 7:00 a.m., the time designated for administering Client #3's Synthroid. In addition, the change in the designated time (to 7:00 a.m.) had been

The facility's nursing staff will provide training for staff on Client #3 medication protocol for Synthroid. QMRP and Residential Manager will monitor weekly to ensure implementation.

10/29/10

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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W 369 Continued From page 23
ordered 8/1/2010, almost 2 months prior to this survey.

W 369

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

W 436

Cross reference W159 #4

10/29/10

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

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

The finding includes:

Observation on 9/23/2010 and again on 9/24/2010 revealed Client #2 wore a soft padded helmet, a gait belt and was provided a hospital bed to sleep on. Record review on 9/24/2010 at 12:07 p.m. revealed, Client #2's Physical Therapy assessment dated 08/03/2009 recommended that he receive a "helmet with a face guard" and identified that his adaptive equipment included a "padded" side rail (on his hospital bed).

The QMRP and the primary nurse will review all recommendations from OT, PT or Speech Pathologist to identify the need for any adaptive equipment on a monthly basis. The padded rail and helmet with face guard will be obtained.

11/2/10

Interview with the facility's qualified mental retardation professional (QMRP) on 9/24/2010 at 12:10 p.m. confirmed the "helmet with a face guard" and the "pads" for the side rails on his hospital bed need edto be purchased.

W 474 483.480(b)(2)(iii) MEAL SERVICES

W 474

Food must be served in a form consistent with the

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

PRINTED: 10/08/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6610 FIRST STREET NW WASHINGTON, DC 20011
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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 474 Continued From page 24 developmental level of the client.	W 474	Cross reference W169 #2, #5	10/29/10
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This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed for one of the four clients residing in the facility. [Client #3]

The finding includes:

Observation on 9/23/2010 at approximately 5:00 p.m. revealed Client #3 was served a meal consisting of tortilla, grilled chicken, re-fried beans, lettuce, tomato, raspberry sherbet, milk and water. Client #3's tortilla, chicken, lettuce and tomato were served chopped. His re-fried beans were mashed and served soft. The milk and water were not altered and served accordingly. During dinner, Client #3 was observed taking large spoons (tablespoon) of food into his mouth. He was also observed not consistently chewing his food as he ate his meal. The facility's qualified mental retardation professional (QMRP) stepped in and advised staff to take the larger spoon away and to provide him with a smaller spoon (teaspoon). Client #3 continued to eat his meal, but this time he ate at a faster pace, seemingly to accommodate the use of the smaller spoon. His attending staff (1:1) provided touch control and asked him to slow down and put down his spoon.

Record review on 9/24/2010 at approximately 10:15 a.m. revealed Client #3's current physician's orders (9/2010) and nutritional (1/2010) assessment identify he has been prescribed to receive all foods in a "mechanically

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

PRINTED: 10/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

(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 474 Continued From page 25 soft - chopped" texture.	W 474	Cross reference W159 #2, #5	10/29/10
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Interview with the facility's qualified mental retardation professional (QMRP) on 9/23/2010 at approximately 6:10 p.m. confirmed Client #3 was prescribed a "mechanically soft - chopped diet" as listed on his 9/2010 physician's order sheet. The QMRP also confirmed staff should have provided Client #3 with a "mechanically soft" textured meal as prescribed by the primary care physician (PCP).

The facility's staff failed to demonstrate the skill and competency necessary to ensure Client #3 received all his meals in the texture prescribed to meet his developmental needs.

PRINTED: 10/08/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

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1 000 INITIAL COMMENTS 1 000

A re-licensure survey was conducted from 9/23/2010 through 9/24/2010.

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

1 055 3502.13 MEAL SERVICE / DINING AREAS 1 055

Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.

All staff will be trained on all individuals diets and food texture.

10/29/10

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure all residents received their meals in the form and consistency as prescribed for one of the four residents of the facility. [Resident #3]

The finding includes:

Observation on 9/23/2010, at approximately 5:00 p.m. revealed Resident #3 was served a meal consisting of tortilla, grilled chicken, re-fried beans, lettuce, tomato, raspberry sherbet, milk and water. Resident #3's tortilla, chicken, lettuce and tomato were served chopped. His re-fried beans were mashed and served soft. The milk and water were not altered and served accordingly. During dinner, Resident #3 was

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Caitann A. Reese Program Director
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE
10/15/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

(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
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I 055 Continued From page 1

observed taking large spoons (tablespoon) of food into his mouth. He was also observed not consistently chewing his food as he ate his meal. The facility's qualified mental retardation professional (QMRP) stepped in and advised staff to take the larger spoon away and to provide him with a smaller spoon (teaspoon). Resident #3 continued to eat his meal, but this time he ate at a faster pace, seemingly to accommodate the use of the smaller spoon. His attending staff (1:1) provided touch control and asked him to slow down and put down his spoon.

Record review on 9/24/2010 at approximately 10:15 a.m. revealed Resident #3's current physician's orders (9/2010) and nutritional (1/2010) assessment identify he has been prescribed to receive all foods in a "mechanically soft - chopped" texture.

Interview with the QMRP on 9/23/2010, at approximately 6:10 p.m., confirmed Resident #3 was prescribed a "mechanically soft - chopped diet" as listed on his 9/2010 physician's order sheet. The QMRP also confirmed staff should have provided Resident #3 with a "mechanically soft" textured meal as prescribed by the primary care physician (PCP).

The facility's staff failed to demonstrate the skill and competency necessary to ensure Resident #3 received all his meals in the texture prescribed to meet his developmental needs.

I 055

I 090 3504.1 HOUSEKEEPING

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

I 090

PRINTED: 10/08/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

(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
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I 090 Continued From page 2
odors.

This Statute is not met as evidenced by:
Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure the interior of the GHMRP was maintained in a safe, orderly, and attractive manner, for four of four residents of the facility. Residents #1, #2 #3 and #4)

The finding includes:

An inspection of the environment was conducted on September 23, 2010, beginning at 11:45 a.m. The ceiling in a closet located in bedroom #3 had water damage. The quality assurance assistant and the qualified mental retardation professional, who had accompanied the surveyor, confirmed the findings at approximately 1:00 p.m.

I 090

Client #3 closet ceiling will be repaired.

10/29/10

I 161 3507.2 POLICIES AND PROCEDURES

The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.

This Statute is not met as evidenced by:
Based on record review, the Group Home for Persons with Mental Retardation (GHMRP) governing body failed to document a review of its policies and procedures annually.

The finding includes:

On 9/24/2010, at 11:46 a.m., review of the policy and procedure manual that was maintained in the home revealed review dates of 9/1/2006, 11/20/2010 and 2/12/2010. No additional

I 161

CMS Policies and Procedures Manual was reviewed and signed by Program Director.

10/8/10

PRINTED: 10/08/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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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) COMPLETE DATE
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I 161 Continued From page 3
information was presented before the survey ended later that day.

I 161

All staff will be trained on individuals diets, food texture, BSP and proper documentation of both bowel movements and BSP behaviors.

10/29/10

I 180 3508.1 ADMINISTRATIVE SUPPORT

Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

I 180

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure qualified mental retardation professional (QMRP) services to meet residents' needs, for three of the four residents of the facility. [Residents #1, #2 and #3]

QMRP will ensure all individuals receive their recommended adaptive equipment as well as Client #2 receives an ambulating protocol and all staff are trained on the ambulating protocol.

10/29/10

The findings include:

1. [Cross Reference I229] The QMRP failed to ensure all staff received effective training on the implementation of Resident #3's food texture requirements, Resident #1's behavior support plan and proper documentation of Resident #1's bowel movements.
2. [Cross Reference Federal Deficiency Report Citation W252] The QMRP failed to ensure that staff documented all incidents of Resident #1's observed maladaptive behaviors.
3. [Cross Reference Federal Deficiency Report Citation W436] The QMRP failed to ensure all residents received their recommended adaptive equipment.
4. [Cross Reference I055] The QMRP failed to ensure all residents received their meals in the

PRINTED: 10/08/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

(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
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I 180 Continued From page 4 prescribed texture.

5. [Cross Reference I441] The facility's QMRP failed to ensure Resident #2's ambulation protocol was available and presented to all staff to ensure consistent implementation while assisting the resident while ambulating.

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 Mental Retardation (GHMRP) failed to ensure all staff received training on the implementation of Resident #1's behavior support plan, use of Resident #2's gait belt and Resident #3's prescribed food texture, for three of the four residents of the facility. [Resident #1]

The findings include:

1. [Cross Reference I422.2] Review of staff in-service trainings record on 9/24/2010, at approximately 2:55 p.m., revealed that training on Resident #1's behavior support plan (BSP) was offered on 2/26/2010. Further review, however, revealed that only five (5) out of the facility's ten (10) currently employed staff had attended the training.

Cross reference W159 #8	10/29/10
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
---	---

(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
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I 229 Continued From page 5

I 229

Cross reference W159 # 2

10/29/10

Interview with the facility's house manager (HM) on 9/24/2010 at approximately 2:58 p.m. confirmed there were no other BSP trainings held other than the 2/26/2010 training. The HM further confirmed what was documented on the 2/26/2010 BSP training was true and a factual representation of the staff that attended the training.

2. [Cross Reference I055] Record review on 9/24/2010 at approximately 2:45 p.m. revealed there was no documented evidence that any of the facility's ten (10) staff received training on Resident #3's food texture requirements dating back to 9/1/2009.

Interview with the facility's house manager (HM) on 9/24/2010 at approximately 2:50 p.m. confirmed none of the currently employed staff (10 staff) had received training on Resident #3's modified food texture requirements. In addition, the HM also confirmed there was no additional staff training documents on hand to review.

The facility failed to ensure all staff received training on Resident #3's modified food texture requirements to meet his developmental needs.

3. [Cross Reference I401.3] On 9/23/2010, beginning at 2:54 p.m., review of Resident #1's bowel movement (BM) charts revealed that direct support staff on each shift were instructed to enter a zero if he had no BM during their shift or use a symbol listed in the legend below the chart to document and describe every BM. [Example: H = Hard Stool (small rocks)] Continued review of the BM charts revealed numerous gaps where staff failed to provide data from their shift. Failure to document BMs during the past 3 months was noted on each of the three shifts.

PRINTED: 10/08/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR 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
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I 229 Continued From page 6 I 229

On 9/24/2010, at approximately 12:35 p.m., the RN stated that she had provided training to staff on documenting residents' BMs on the BM chart. The RN agreed to seek training records for direct support staff and to contact the Director of Nursing to request evidence of training received by their nursing staff within the past 6 months. Review of staff in-service training records a short time later, beginning at approximately 2:55 p.m., failed to show evidence that the facility's nine (9) direct support staff and the house manager had received training on proper documentation of Resident #1's BMs. No additional information was provided for review before the survey ended later that afternoon.

I 401 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS I 401

Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure residents received timely medical assessment and nursing services, for two of the four residents residing in the facility. [Residents #1 and #3]

The findings include:

1. The facility's nursing staff failed to ensure that Resident #1 received a timely medical assessment, as follows:

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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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) COMPLETE DATE
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I 401 Continued From page 7 I 401

On 9/23/2010, at approximately 11:50 a.m., Resident #1's day program activities coordinator stated that the resident had hit himself and others while at the day program on 9/20/2010 and 9/21/2010. He had worked with the resident since 2001 and he had only seen the resident become assaultive when he was "impacted." He said that was the resident's way to express pain or discomfort. The resident stayed home on 9/22/2010, after the home agreed on 9/21/2010 to have him evaluated. [Note: The resident returned to day program on 9/23/2010 with no communication received from the home documenting a physical examination.] Review of Resident #1's behavior support plan (BSP) dated 10/6/2009, confirmed "constipation" was the first antecedent listed for targeted behaviors of physical aggression towards others and self-injurious behaviors.

On 9/23/2010, at 3:11 p.m., review of Resident #1's primary care physician (PCP) notes revealed the most recent entry was dated 7/30/2010. The house manager (HM) stated that the resident had an appointment scheduled with the PCP on the next day, 9/24/2010. Subsequent review of the resident's Nurse's Progress Notes revealed entries dated 9/21/2010 at 6 p.m., 9/22/2010 at 7:30 a.m. and 9/23/2010. None of those three entries indicated that a nurse had assessed the resident's abdomen and bowels during the three days. The above-cited nurse progress notes reflected reviews of his BM habits on those dates.

The resident was taken to a hospital emergency room (ER) on the evening of 9/23/2010 due to "blood in the urine." The ER discharge report stated that lab testing failed to show blood in the urine. Further review of the ER discharge papers

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2010
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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1401	Continued From page 8	1401	Cross reference W331	11/2/10
	<p>revealed no indication that any diagnostic procedures other than labs/blood in urine had been performed at the hospital.</p>			
	<p>An entry made by the RN on 9/24/2010 at 7:40 a.m. revealed that "individual in no distress" and she had taken his vital signs. The entry, however, did not suggest an assessment of the resident's abdomen was performed.</p>			
	<p>Resident #1 was taken to the PCP's office for evaluation on 9/24/2010, at approximately 3:30 p.m., which was 3 days after the day program expressed concerns that his assaultive behaviors might be due to physical discomfort.</p>			
	<p>It should be noted that staff had documented BMs on the evening shift of 9/18/2010, evening shift of 9/20/2010, evening shift of 9/21/2010, evening shift of 9/22/2010 as well as the morning shifts on 9/23/2010 and 9/24/2010. Nursing staff, therefore, referred to those BMs as evidence that Resident #1 was not impacted.</p>			
	<p>2. The facility's nursing staff failed to ensure that Resident #1 consistently received stool softener as needed (PRN), in accordance with his physician's orders (POs), as follows:</p>			
	<p>a. [Cross Reference W368.3] On 9/23/2010, Resident #1's day program activities coordinator expressed concern re: the resident's bowel movements and the potential for fecal impaction. Review of Resident #1's 9/2010 physician's orders (POs) revealed that since 1/24/1994, he was to receive "Milk of Magnesia 400 mg/5 ml oral suspension, give 45 cc by mouth every 3rd day as needed for constipation if no BM." On 9/23/2010, beginning at 2:54 p.m., review of Resident #1's MARs along with a review of the</p>			

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I 401 Continued From page 9

I 401

resident's Bowel Movement (BM) charts revealed that he had gone without a documented BM on 7/22/2010, 7/23/2010 and 7/24/2010 without receiving the PRN Milk of Magnesia (MOM). The BM chart for 9/2010 showed no documented BM on 9/6/2010, 9/7/2010 and 9/8/2010. A nurse documented having administered MOM at 7 p.m. on 9/9/2010 (the 4th day), which was not in accordance with the POs.

b. On 9/24/2010, at approximately 12:57 p.m., interview with the RN revealed that the evening medication nurse had been instructed to review Resident #1's BM chart every 3 days and if there had been no BM, the nurse should administer the MOM, as needed. At approximately 3:20 p.m., review of the resident's 9/2010 MAR revealed that the exact dates for said review by the evening nurse had been designated on the MAR every 3 days, beginning on 9/3/2010. The evening nurse documented having reviewed the resident's BM chart on 9/3/10 but missed a review on 9/6/2010. The nurse documented a review on 9/9/2010 and 9/12/2010 but then missed a review on 9/15/2010. The evening nurse(s) failed to document a review of Resident #1's BM chart every 3 days as instructed.

It should be noted that during the survey and again during the Exit conference, the qualified mental retardation professional stated that the order was "if he goes 3 days without a BM." This, however, was not consistent with how the order reads. They agreed to seek further clarification from the PCP.

3. The facility's nursing staff failed to ensure that direct support staff consistently documented Resident #1's BM's, as follows:

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I 401 Continued From page 10 I 401

As noted above, Resident #1's POs dated 9/2010, revealed "chronic constipation" as an ongoing diagnosis. He received Miralax and prune juice daily. The POs also included "Milk of Magnesia 400 mg/5 ml oral suspension, give 45 cc by mouth every 3rd day as needed for constipation if no BM." On 9/23/2010, beginning at 2:54 p.m., review of the resident's BM charts revealed that direct support staff on each shift were instructed to enter a zero if he had no BM during their shift or use a symbol listed in the legend below the chart to document and describe every BM. [Example: H = Hard Stool (small rocks)] Continued review of the BM charts revealed numerous gaps where staff failed to provide data from their shift. Failure to document BMs during the past 3 months was noted on each of the three shifts, as follows:

- a. 12 a.m. - 8 a.m. shift - staff failed to make entries on 7/1/2010, 7/26/2010, 8/1/2010, 8/2/2010, 8/5/2010 and 8/30/2010;
- b. 8 a.m. - 4 p.m. shift - there was no data on his BM chart on 7/2/2010, 7/10/2010, 7/11/2010, 7/19/2010, 7/22/2010, 7/23/2010, 8/6/2010, 8/31/2010, 9/1/2010, 9/14/2010 and 9/23/2010; and,
- c. 4 p.m. - 12 a.m. shift - staff failed to make entries on 7/31/2010, 8/1/2010, 8/6/2010, 8/14/2010 and 8/15/2010.

On 9/24/2010, at approximately 12:35 p.m., the RN stated that she had provided training to staff on documenting residents' BMs on the BM chart. The RN agreed to seek training records for direct support staff and to contact the Director of Nursing to request evidence of training received by their nursing staff within the past 6 months.

PRINTED: 10/06/2010
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1401	Continued From page 11 Review of staff in-service training records a short time later, beginning at approximately 2:55 p.m., failed to show evidence that the facility's nine (9) direct support staff and the house manager had received training on proper documentation of Resident #1's BMs. No additional information was provided for review before the survey ended later that afternoon. 4. The facility's nursing staff failed to ensure that all medications listed on Resident #3's physician's orders were available "as needed." On 9/23/2010, at 8:59 a.m., while verifying the morning medication pass observations, Resident #3's POs included "ProAir (Albuterol) HFA 90 mcg AER w/Adap Inhale 2 puffs every 6 hours as needed." The POs indicated that the Albuterol was first ordered on 4/4/2008; however, there was no reason given for this PRN medication. At 9:03 a.m., the medication nurse looked through the medication cabinet twice and stated that there was no Albuterol available. He suggested that it may have been discontinued; however, we did not find an order to discontinue the medication. At approximately 10:55 a.m., the recently-hired qualified mental retardation professional (QMRP) and the HM indicated they were not aware of any reason why Resident #3 might need to use Albuterol. The QMRP immediately presented a Medical Assessment dated 11/27/2009, and upon its review, stated that she saw no indications for the PRN medication. On 9/24/2010, at approximately 1:00 p.m., the recently-hired RN stated that Albuterol was typically prescribed for treating asthma. She indicated that she was previously unaware that Albuterol PRN was prescribed PRN on Resident #3's POs. She replied "no" when asked if the	1401		

PRINTED: 10/06/2010
FORM APPROVED

Health Regulation Administration

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I 401 Continued From page 12

medication nurse had informed her of his search for it on the previous day. At approximately 2:20 p.m., the RN indicated that the PCP had just informed her the Albuterol had been needed only back at the time it was ordered in 2008. She then presented a handwritten order to discontinue the Albuterol, signed that day by the PCP.

There was no evidence that the facility's nurses and medical team reconciled physician's orders with the medications-on-hand to ensure that medications prescribed for PRN use readily available if and when needed by the resident.

I 401

I 422 3521.3 HABILITATION AND TRAINING

Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.

This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to implement training programs, behavior support plans and mealtime protocols as recommended by the interdisciplinary team, for two of the four residents of the facility. [Residents #1 and #3]

I 422

The findings include:

1. On 9/23/2010, at approximately 7:34 a.m., Resident #1 (who is non-verbal) walked over to Staff #1 and stood in front of him. The staff reached for the resident's belt while stating that this was the resident's means of informing him that he needed to use the bathroom and the resident was unable to undo the belt. After the staff unfastened the belt, the resident went upstairs to use the bathroom. On 9/24/2010, at

All staff will be trained on individual #2 IPP goals. The management team will review IPP documentation weekly and staff will receive ongoing training on documentation for all IPP goals.

10/29/10

PRINTED: 10/08/2010
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I 422 Continued From page 13

I 422

3:59 p.m., review of Resident #1's Individual Support Plan, dated 9/25/2009, revealed that he had a training program for him to learn to fasten and unfasten his belt. The plan stated that staff should provide "verbal prompts" and encourage him to unbuckle his belt. Observations revealed that staff working with him on the morning of 9/23/2010 failed to implement his program when the opportunity presented itself.

2. [Cross Reference Federal Deficiency Report Citation W193.1] Facility staff failed to consistently implement Resident #1's BSP. On the evening of 9/23/2010, Resident #1 was observed hitting himself on the face and vocalizing loudly. He also attempted to hit a direct support staff. He repeated the behaviors several times until dinner was served.

Record review on 9/24/2010, at approximately 12:05 p.m., revealed Resident #1's Behavior Support Plan (BSP), dated 10/14/2009, revealed that staff should "Offer him a formal choice...physically redirect him to another activity...create a 'safety zone' if the aggression continues to escalate and he is disrupting the entire situation staff should either get him into another area or room or remove others from the area or room he is in."

Observations, however, had revealed that staff failed to offer Resident #1 "two choices" from the onset, failed to physically redirect him to another activity, did not take him by the elbow into another room, and never established a "safety zone" for him in their effort to address his agitation and aggression. Resident #1 was allowed to remain in the dining room the entire period he was agitated and was physically aggressive towards staff.

Cross reference W193

10/29/10

PRINTED: 10/06/2010
FORM APPROVED

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1422	Continued From page 14 3. Staff failed to implement a Resident #3's mealtime feeding protocol, as follows: [Cross Reference 1055] Observation on 9/23/2010, at approximately 5:00 p.m. revealed staff served Resident #3 his meal in a chopped texture, but failed to ensure the meal was served "mechanically soft" as prescribed by the primary care physician (PCP). Record review on 9/24/2010 at approximately 10:15 a.m. confirmed Resident #3's current physician's orders (9/2010) prescribed he receive a "mechanically soft, chopped" textured diet. Interview with the facility's qualified mental retardation professional (QMRP) on 9/23/2010 at approximately 6:10 p.m. confirmed staff should have provided Resident #3 with a "mechanically soft" textured meal as prescribed by the primary care physician (PCP). The facility's staff failed to demonstrate the skill and competency necessary to ensure Resident #3 received all his meals in the texture prescribed to meet his developmental needs.	1422			
1441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Mental	1441			

PRINTED: 10/08/2010
FORM APPROVED

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I 441 Continued From page 15

I 441

Cross reference W159 #4

10/29/10

Retardation (GHMRP) failed to ensure one of two sampled residents was provided the recommended adaptive equipment to ensure their health and safety for one of two sampled residents. [Resident #2]

The finding includes:

Observation on 9/23/2010, at approximately 12:15 p.m. revealed Resident #2 was wearing a loosely secured gait belt and a soft padded helmet. The helmet appeared to be properly fitted and the gait belt was loosely secured around his waist. During the observation, Resident #2's 1:1 nursing staff (provided by the facility) used his left hand to hold the right side of Resident #2's gait belt as he assisted him to ambulate around the facility. On other occasions, he was observed holding to the back of Resident #2's gait belt as he walked behind him. Later on the same day at approximately 4:20 p.m., Resident #2 returned home from his day program. Upon exiting the van, the attending nurse and one of the van staff each grabbed under Resident #2's armpits and assisted him up the stairs to the front door of the facility. The attending nurse was then observed to continue the hold under Resident #2's left arm and assisted him up the stairs to his bedroom. Record review on 9/24/2010 at 12:08 p.m. revealed, Resident #2's Physical Therapy assessment dated 08/03/2009 recommended that the facility "Continue [sic] ambulation protocol." Further record review and interview with the facility's qualified mental retardation professional (QMRP) on 9/24/2010 at approximately 3:00 p.m. revealed, there was no documented evidence an ambulation protocol was drafted and on file for review. The QMRP also checked Resident #2's habilitation records

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I 441 Continued From page 16

I 441

and confirmed that document was not on file. The facility's QMRP failed to ensure the ambulation protocol was available and presented to all staff to ensure a consistent implementation of Resident #2's ambulation protocol.