

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

PRINTED: 02/01/2010  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/08/2010
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 8TH 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 000)	INITIAL COMMENTS  A revisit was conducted on January 4, 2010 and January 5, 2010, to verify the facility's compliance with condition-level deficiencies cited during the November 18, 2009 recertification survey and incident investigation. Two clients remained in the sample from the previous survey and two new clients were added from a residential population of six females with various disabilities. The findings of the survey were based on observations in the home, interviews with clients and staff (direct care, nursing and administrative), as well as a review of clinical, administrative, and rehabilitative records, including a review of unusual incident reports.  The revisit resulted in a determination that the facility had regained compliance with the Condition of Participation in Client Protections. Additionally, some standard-level deficiencies remained, as evidenced by the citations in the report that follows.	(W 000)	2/4/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NDRTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002  Received Revised 4/2/10	
(W 104)	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's governing body provided general operating direction, except in the following areas:  The findings include:  1. Cross-refer to W192. The governing body failed to ensure that all staff were trained and	(W 104)	1. Cross reference W455	1/14/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constantine C. Reese TITLE: Program Director DATE: 2/4/10 (TW)

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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Constantine C. Reese* TITLE *Program Director* DATE *2/4/10*

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{W 124}	<p>Continued From page 2</p> <p>contacted Client #2's and #3's guardians since the November 19, 2009 survey. The QMRP stated that there had been no new sedations ordered prior to medical appointments.</p> <p>2. When asked whether anyone from the facility had reviewed Client #2's health status and medication regimen with her guardian, the QMRP acknowledged that no reviews had occurred. At approximately 10:45 a.m., review of Client #2's medical chart confirmed that there had been no recent discussions or reviews of Client #2's health status (with her guardian) documented. The May 29, 2009 consent form remained in her record as the most recent written consent for her psychotropic medication regimen. That consent form did not reflect the use of Trazodone or indicate a therapeutic range for Thorazine and Depakote (both of which had been increased substantially, in terms of daily dosage).</p> <p>3. Also at approximately 10:45 a.m., review of Client #3's medical and habilitation records showed no evidence that the facility had reviewed her health status and treatment needs/options with her guardian, and no written consent was found in her records. The QMRP said she would look for a signed consent form for Client #3. When interviewed on January 5, 2010, at 9:45 a.m., the QMRP repeated what she had stated the day before, that the facility had not reviewed the clients' restrictive behavior support plans with their respective legal guardians after the November 19, 2009 survey.</p> <p>It should be noted that on December 23, 2009, the facility submitted a Plan of Correction (POC). Review of the POC, however, revealed that it failed to address the immediate need to contact</p>	{W 124}	<p>2. The facility will obtain an informed consent from the court appointed legal guardian prior to the administration of her psychotropic medications. All potential risks involved in using the medication will also be explained. In the future, the Human Right's Committee will review obtained consent prior to approving administration of psychotropic medications.</p> <p>3. Cross reference W124</p>	<p>2/28/10</p> <p>2/28/10</p>
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{W 124}	<p>Continued From page 3</p> <p>the clients' legal guardians to review the potential risks and benefits associated with psychotropic medications and obtaining written consent for administering the medications.</p> <p>.....</p> <p>Previously, the November 19, 2009 findings had included the following:</p> <p>1. There was no evidence that the facility informed Client #2 and her court appointed guardian of her health status and treatment needs, to include the potential risks and benefits associated with new psychotropic medications (or significant increases in dosage) and obtained written consent prior to administering the medications, as follows:</p> <p>Observation of the evening medication pass on November 16, 2009 revealed that Client #2 received Depakote 1000 mg, Thorazine 400 mg, Trazodone 100 mg and Abilify 30 mg. During the entrance conference, the QMRP and HM had indicated that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The client had a court appointed guardian to assist her in making healthcare decisions. The client's medical records were reviewed on November 18, 2009 beginning at 11:38 a.m.</p> <p>Her physician's orders (POs) indicated that Trazodone 50 mg was first ordered on August 3, 2009, with the first dose documented on her Medication Administration Record (MAR) as administered the next evening (August 4, 2009). The Trazodone was then doubled to 100 mg</p>	{W 124}		

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{W 124} Continued From page 4  
daily, effective October 16, 2009.  
Client #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 mg daily, effective October 17, 2009; and, an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.

On November 18, 2009 at 2:53 p.m., the most recent consent form in Client #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented) use of Trazodone and increases in Thorazine and Depakote. A telephone call was placed to the client's court-appointed guardian on November 18, 2009 at 2:09 p.m. She did not, however return the message before the survey ended the following day at 2:52 p.m.

It should be noted that on November 17, 2009 beginning at 2:28 p.m., review of the facility's Human Rights Committee minutes revealed that on September 5, 2008, the committee approved a recommended decrease in Client #2's daily Thorazine after the client complained of drowsiness/sedation.

2. Similarly, review of Client #3's medical record and interviews with the QMRP on November 17, 2009 failed to provide evidence that the client's treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment,

{W 124}

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{W 124}  W 130	<p>Continued From page 5 had been explained to her and/or her court appointed legal guardian. 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the six clients residing in the facility. (Client #2)</p> <p>The finding includes:</p> <p>On January 4, 2010, a male nurse arrived at the facility at 6:57 a.m. He went upstairs immediately to begin preparing for the morning medication administration. This surveyor went upstairs at approximately 7:00 a.m. A direct support staff person and two clients were standing in the hallway, opposite the door to the office/nurse station. After a brief interchange with another client, this surveyor looked across the hallway and saw Client #2 in her bedroom. The door was fully open. Her bedroom was situated immediately next door to the office/nurse station.</p> <p>Client #2 was seated on the edge of her bed, completely naked and looking out the bedroom door. She laughed aloud when she heard this surveyor calmly express "oh my." The staff person standing directly across the hall from Client #2's bedroom door (and within view of the naked client) did not say anything or otherwise intervene. After a momentary pause, this</p>	{W 124}  W 130	<p>A case conference was held on 1/11/10 regarding Client #2's behavior of expressing herself to men and begging for money. The psychologist assessed these behaviors and recommended for the facility to document baseline data before addressing these behaviors in her Behavior Support Plan. In the future, staff will receive ongoing training quarterly regarding ensuring privacy during treatment and care of personal needs.</p>	1/11/10
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(W 124)  W 130	<p>Continued From page 5 had been explained to her and/or her court appointed legal guardian.</p> <p><b>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the six clients residing in the facility. (Client #2)</p> <p>The finding includes:</p> <p>On January 4, 2010, a male nurse arrived at the facility at 8:57 a.m. He went upstairs immediately to begin preparing for the morning medication administration. This surveyor went upstairs at approximately 7:00 a.m. A direct support staff person and two clients were standing in the hallway, opposite the door to the office/nurse station. After a brief interchange with another client, this surveyor looked across the hallway and saw Client #2 in her bedroom. The door was fully open. Her bedroom was situated immediately next door to the office/nurse station.</p> <p>Client #2 was seated on the edge of her bed, completely naked and looking out the bedroom door. She laughed aloud when she heard this surveyor calmly express "oh my." The staff person standing directly across the hall from Client #2's bedroom door (and within view of the naked client) did not say anything or otherwise intervene. After a momentary pause, this</p>	(W 124)  W 130	<p>A case conference was held on 1/11/10 regarding Client #2's behavior of expressing herself to men and begging for money. The psychologist assessed these behaviors and recommended for the facility to document baseline data before addressing these behaviors in her Behavior Support Plan.</p>	1/11/10
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W 130  {W 137}	<p>Continued From page 6</p> <p>surveyor informed the staff that Client #2 might need assistance with ensuring her privacy. The staff looked at Client #2 and instructed her to put on some clothes. She then walked a few steps across the hall and closed the bedroom door.</p> <p>It should be noted that the November 19, 2009 recertification survey had revealed Client #2 had a history of exposing herself to male nurses. The behavior, however, had not been assessed and there were no intervention strategies established, to date. [See W214.2]</p> <p><b>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients had the right to access their personal clothing, for one of the four clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On December 23, 2009, the facility submitted a Plan of Correction (POC) to address the deficiencies cited during the November 19, 2009 survey. According to the POC, the qualified mental retardation professional (QMRP) "will have a case conference with the Interdisciplinary Team (IDT) team to discuss Client #2's behavior of discarding shoes and clothing items. The QMRP will request this behavior to be addressed in her Behavior Support Plan."</p>	W 130  {W 137}	<p>A case conference was held on 1/11/10 regarding Client # 2's right to access her personal clothing. The psychologist recommended for the facility to take baseline data of Client #2's selling or discarding her personal clothing before addressing this behavior in her Behavior Support Plan.</p>	1/11/10

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{W 137}	Continued From page 7  On January 4, 2010, at approximately 11:45 a.m., observations and interview with the QMRP, revealed that there were no clothes or shoes in Client #2's closet. The QMRP stated that on December 7, 2009, the facility's Human Rights Committee had reviewed and approved restriction of Client #2's access to her clothes and shoes. She further stated that the case conference had not yet occurred because some members of the IDT and the guardian had not been available. A case conference reportedly was scheduled for January 11, 2010.	{W 137}		
{W 192}	483.430(e)(2) STAFF TRAINING PROGRAM  For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all staff were trained and competent to provide assistance in accordance with the health care needs, for two of the four clients in the sample. (Clients #1 and #2)  The findings include:  On January 4, 2010, at 9:05 a.m., interview with the qualified mental retardation professional revealed that since the November 19, 2009, survey, staff had received training on dietary supports/nutrition and on infection control. She presented documentation for both trainings, dated December 18, 2009, and December 23, 2009, respectively. She further stated that there had been no other in-service training provided, to	{W 192}	Cross reference W455	1/14/10

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{W 192}	Continued From page 8 date.	{W 192}		
{W 214}	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a comprehensive assessment that depicted there behavior management needs, for two of the four clients in the sample. (Clients #2 and #4)</p> <p>The findings include:</p> <p>1. On December 23, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited during the November 19, 2009, survey. According to the POC, the qualified mental retardation professional (QMRP) would consult with the psychologist about addressing Client #2's behaviors of begging for money and exposing herself to men. The January 5, 2010, revisit revealed that, to date, the client's behaviors continued and they had not been assessed by the</p>	{W 214}	<p>1a. Cross reference W130</p>	<p>1/11/10</p>

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{W 214}	Continued From page 9 psychologist, as follows:  a. On January 4, 2010, at 7:38 a.m., Client #2 asked a nurse for \$3 after they had completed the morning medication administration. The nurse declined her request. After the client left the room, he indicated that she had asked him for money approximately six weeks earlier. Later that day, at 3:12 p.m., Client #2 was observed standing in the dining area with staff and peers after returning home from day program. She immediately walked over to this surveyor and asked for 3 dollars. At 3:34 p.m., the client asked the surveyor for 3 dollars while standing in the kitchen area with staff. At 3:44 p.m. and 3:46 p.m., Client #2 again asked the surveyor for 3 dollars.  Interview with the QMRP on January 5, 2010, at approximately 11:00 a.m., revealed that the psychologist had been made aware of Client #2's money-begging behavior. To date, however, the psychologist had not fully assessed her. Further interview with the QMRP revealed that the client's guardian was unavailable to meet with the interdisciplinary team before January 11, 2010.  b. Similarly, interview with the QMRP on January 4, 2010, at approximately 11:00 a.m. and again at 5:30 p.m. revealed that Client #2's tendency to expose herself to men had not yet been assessed by the psychologist. Earlier that morning, at approximately 7:00 a.m., Client #2's bedroom door remained wide open while a male nurse was in an adjacent room, other clients and staff were in the hallway outside of her bedroom and a male surveyor was in the facility. The client laughed when the surveyor observed that she was fully naked. [See W130]	{W 214}	1b. Cross reference W130	1/11/10	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/08/2010
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011
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{W 214}	Continued From page 10  2. The facility's POC to address deficiencies cited on November 19, 2009 indicated that the QMRP would obtain the findings of Client #4's sexuality assessment that was reportedly performed on September 11, 2009. However, on January 5, 2010, at 10:28 a.m., interview with the QMRP revealed that the facility still had not obtained a copy of the September 11, 2009 assessment report. It should be noted, however, that a consultation form documented that Client #4 had returned to the same sexuality clinician on December 30, 2009 for counseling.	{W 214}	2. The facility obtained Client #4's sexuality assessment.	1/8/10
{W 242}	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN  The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene and personal grooming/ hair care, for one of the four clients in the sample. (Client #3)  The finding includes:  1. On December 23, 2009, the facility submitted a Plan of Correction (POC) in which they indicated that the QMRP would add a toothbrushing goal to Client #3's IPP to address poor oral hygiene by	{W 242}	1. The QMRP added a toothbrushing goal to Client #3's IPP to address poor oral hygiene. The QMRP will ensure that each individual IPP addresses training in activities of dental hygiene and/or personal grooming.	2/1/10

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011
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{W 242}	<p>Continued From page 11 January 8, 2010.</p> <p>Interview with the QMRP on January 5, 2010, at 10:40 a.m., revealed that she had not added a toothbrushing goal to address Client #3's poor oral hygiene (as indicated in the September 2009 dental consultation). Further interview with the QMRP revealed that Client #3's toothbrushing goal would be added at the six (6) month quarterly review in February 2010. The facility failed to address the client's need to improve his/her hygiene in a timely manner.</p> <p>2. The facility's POC, dated December 23, 2009, also indicated that the QMRP "will consider adding on additional home goals to address grooming and hair care needs at the next quarterly review by January 24, 2010."</p>	{W 242}	<p>2. The QMRP added an additional home goal that addresses grooming and care needs to Client #3's IPP.</p>	2/1/10
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{W 252}	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for two of the four clients in the sample. (Clients #2</p>	{W 252}		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2010
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011
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{W 252}	<p>Continued From page 12 and #4</p> <p>The findings include:</p> <p>1. On January 4, 2010, at 3:47 p.m., Client #4 left the dining room table, walked over to a surveyor sitting on the living room sofa and started touching the surveyor on his left shoulder. The client's 1:1 staff remained seated at the dining table for approximately thirty (30) seconds until verbally prompted by the qualified mental retardation professional (QMRP) to redirect the client. Following this prompt, the 1:1 staff told the client "no touching" and redirected her away from the surveyor. Interview with the 1:1 staff revealed that Client #4 had a Behavior Support Plan (BSP) to address her maladaptive behaviors, one of which was inappropriate touching.</p> <p>On January 5, 2010, at 11:05 a.m., review of the Client #4's BSP, dated May 27, 2009, confirmed that "inappropriate touching (non-sexual touching of others)" was one of the client's targeted behaviors. Further review of the BSP revealed that all incidents of targeted behaviors were to be recorded at the end of each shift. At 11:10 a.m., review of the data collection sheets revealed that staff failed to document the inappropriate touching that they had witnessed on January 4, 2010.</p> <p>2. Following the November 19, 2009, survey, the facility submitted a Plan of Correction (POC), dated December 23, 2009, that indicated staff "will receive adequate training on documenting maladaptive behaviors by January 15, 2010."</p> <p>On January 5, 2010, at 12:20 p.m., interview with the QMRP on confirmed that the touching</p>	{W 252}	<p>1. An in-service training was held on 1/14/10 by the psychologist regarding documenting maladaptive behaviors, minimizing behaviors and intervention strategies.</p> <p>2. Cross reference W252.1</p>	<p>1/14/10</p> <p>1/14/10</p>
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{W 252}	Continued From page 13	{W 252}		
{W 263}	<p>behavior and soda incident had not been documented on the previous day. Further interview with the QMRP revealed that staff had not received training on data collection since the November 19, 2009, survey.</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>Cross-refer to W124. The January 5, 2010 follow-up survey findings revealed that this remained essentially uncorrected since the November 19, 2009 survey. There was no consent form found in Client #3's record and the consent form observed in Client #2's record was the same (May 29, 2009) form that was addressed in the November 19, 2009 deficiency report.</p> <p>On January 4, 2010, at approximately 11:15 a.m., the qualified mental retardation professional stated that the facility's Human Rights Committee had not met since the last survey. There was no evidence that the committee had determined</p>	{W 263}	<p>Cross reference W124.2</p>	2/28/10

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{W 263}	<p>Continued From page 14</p> <p>whether or not Client #2's and #3's medical guardians had given written, informed consent for restrictive behavior intervention plans, including the use of psychotropic medications.</p> <hr/> <p>Previously, the November 19, 2009 survey findings included:</p> <p>Minutes taken at meetings of the facility's Human Rights Committee for the period September 8, 2008 - November 2009 were reviewed on November 17, 2009 beginning at 2:28 p.m. Client #2's medical chart, including written consents, were reviewed on November 18, 2009 beginning at 11:38 a.m. Client #3's medical chart was reviewed on November 17, 2009 beginning at 9:45 a.m.</p> <ol style="list-style-type: none"> <li>1. Cross-refer to W124.1. The facility failed to obtain consents prior to the use of sedation for Client #3's medical appointments and/or to notify her court appointed legal guardian of the risk and benefits of treatments.</li> <li>2. Cross-refer to W124.2. The facility failed to ensure that informed consent was obtained prior to the administration of Client #3's psychotropic medications.</li> <li>3. Cross-refer to W124.3. The facility failed to ensure that informed consent was obtained from Client #2's court appointed guardian prior to administering new psychotropic medications (Trazodone) or implementing significant increases in the daily dosage of Depakote and Thorazine.</li> </ol>	{W 263}		
{W 322}	483.460(a)(3) PHYSICIAN SERVICES	{W 322}		

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{W 322}	<p>Continued From page 15</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely review and intervention by the medical team, for one of the two clients residing in the facility using CPAP machines to address sleep apnea and for one client involved in client to client abuse. (Client #2 and #3)</p> <p>The findings include:</p> <p>The January 5, 2010 follow-up survey revealed that Client #2, who was diagnosed with sleep apnea, was still refusing to use her CPAP machine at night. There was little activity or progress documented since the November 19, 2009 survey. The facility's Plan of Correction (POC), dated December 23, 2009, included the following corrective actions:</p> <ol style="list-style-type: none"> <li>"In the future, the physician and nurse's notes will include the use of CPAP." On January 4, 2010, at 12:17 p.m., review of Client #2's medical records revealed that the RN had documented the client's non-compliance with the CPAP machine on a December 7, 2009 monthly note for November. The RN also included the following in her November 20, 2009, Quarterly review: "Recommendations, Follow BSP with use of Nasal CPAP, needs consistent reinforcement. PCP should address use of CPAP/alternative/next action plan."</li> <li>The POC indicated that "In the future, the PCP</li> </ol>	{W 322}	<p>1. Cross reference W322.2</p>	<p>1/8/10</p>
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(W 322)	<p>Continued From page 16</p> <p>will review and monitor the use of Client #2's CPAP machine on a quarterly basis. Evidence of the review will be reflected in the PCP's quarterly notes." On January 5, 2010, at approximately 12:14 p.m., the RN acknowledged that to date, there was no evidence that the PCP had reviewed, monitored the CPAP machine and developed an 'action plan' as recommended in the RN's Quarterly Review dated November 20, 2009.</p> <p>3. The POC indicated that "The primary RN will receive training on CPAP." On January 5, 2010, at approximately 12:12 p.m., interview with the RN revealed that she had not yet received training on the CPAP machine.</p> <p>4. The POC indicated that "staff will receive adequate training by the psychologist on documenting behavior data." On January 4, 2010, at 9:05 a.m., interview with the qualified mental retardation professional revealed that since the November 19, 2009 survey, staff had not received training on behavior support plans and/or data collection. On January 5, 2010, at approximately 12:12 p.m., the QMRP again stated that the psychologist had not reviewed the May 2009 BSP and had not yet provided staff in-service training.</p> <p>5. The POC indicated that "a case conference will be held with the IDT including the psychologist to discuss recommendations and/or interventions necessary as a result of Client #2 refusing to wear her CPAP machine." On January 4, 2010, at approximately 10:30 a.m., the QMRP stated that a case conference was scheduled for January 11, 2010. Later that day, at approximately 5:35 p.m., the QMRP further</p>	(W 322)	<p>2. The primary physician addressed the use of the CPAP on his 1/8/10 note, Client is referred to ENT to consider surgical intervention.</p> <p>3. Training for the primary RN regarding the use of CPAP is scheduled on 2/5/10.</p> <p>4. Cross reference W252</p> <p>5. A case conference was held on 1/11/10 and the psychologist recommended for the primary care physician to explore other medical alternatives.</p>	<p>1/8/10</p> <p>2/5/10</p> <p>1/14/10</p> <p>1/11/10</p>
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{W 322}	<p>Continued From page 17</p> <p>indicated that the psychologist would update Client #2's BSP after the case conference. Therefore, as of January 5, 2010, this citation remained unresolved.</p> <hr/> <p>Previously, the November 19, 2009 deficiency report included the following:</p> <p>On November 18, 2009 at approximately 11:50 a.m., review of Client #2's physician's orders (POs) revealed a hand written order for "CPAP" on her August 2009 POs. Beginning April 2009, the diagnosis "Obstructive Sleep Apnea" was added to her POs. Her POs also indicated that she had been receiving Melatonin 3 mg every evening since May 15, 2008. Trazodone 50 mg was added to her evening medication regimen on August 4, 2009. The Trazodone was increased to 100 mg daily, effective October 15, 2009. Although the POs did not indicate why the Trazodone was prescribed, interview with the qualified mental retardation professional (QMRP) and house manager (HM) at approximately 3:30 p.m. revealed that its sedative effect was used to promote sleep.</p> <p>1. At approximately 3:35 p.m., review of her Health Management Care Plan (HMCP) dated May 29, 2009 revealed that direct support staff were to "encourage use of CPAP machines during hours of sleep." The client was to "gradually tolerate use of CPAP machine." The QMRP and HM explained that the client had been refusing to wear the CPAP mask and a behavior support plan (BSP) had been developed by a psychologist. Further review of the HMCP revealed that the RN and primary care physician</p>	{W 322}		
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4314 6TH STREET NW WASHINGTON, DC 20011</b>
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{W 322}	<p>Continued From page 18</p> <p>(PCP) were to monitor the progress. There was no documented evidence, however, that nurses and/or the PCP had monitored the use of the CPAP and made appropriate recommendations.</p> <p>On November 19, 2009 at approximately 11:07 a.m., interview with the RN revealed that she had not observed staff implementing Client #2's BSP for gradually tolerating use of the CPAP mask. She explained that she worked during daytime hours only. She indicated that she had not received training on how to use the CPAP machine. She further stated that to date, she had not discussed the issue of the client rejecting the CPAP machine with the facility's Director of Nursing or the primary care physician (PCP).</p> <p>2. On November 19, 2009 beginning at approximately 9:50 a.m., Client's #2's BSP dated April 14, 2009 was reviewed. It addressed the client's refusal to wear the CPAP mask. At approximately 10:30 a.m., review of Client #2's behavior data sheets revealed marginal cooperation with the program in May and June 2009. Refusals to use the CPAP mask were documented beginning July 2, 2009, with continued refusals documented almost every night in August, September and October 2009. There was no behavior data sheet for the 4:00 p.m. - 12 midnight shift for November 2009. At 10:43 a.m., the HM examined the book and stated "No, I don't see it." She located a data sheet for the 12 midnight - 8:00 a.m. shift. She acknowledged, however, that staff had recorded data only on one of the first 19 days that month (November 1, 2009).</p> <p>3. On November 19, 2009 at approximately 11:12 a.m., interview with the QMRP revealed</p>	{W 322}		
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{W 322}	<p>Continued From page 18</p> <p>that she had not observed the use of Client #2's CPAP machine since she was assigned to "fill-in" for the QMRP (who was away on leave at the time of the survey). She thought the permanent QMRP and/or psychologist would document their reviews in the client's record. Subsequent review, however, of QMRP monthly and quarterly summaries revealed no evidence that the QMRP had brought the issue of the client rejecting the CPAP machine to the attention of the facility's Director of Nursing or the primary care physician (PCP).</p> <p>4. Even though Client #2's record reflected that she had been refusing to cooperate with the use of the CPAP machine since early July 2009 (almost 5 months before the survey), review of the client's record revealed no evidence that the psychologist had monitored the client's CPAP-related BSP since its initiation in May 2009. On November 19, 2009 at 11:20 a.m., the QMRP and the RN acknowledged that there was no evidence that the psychologist had been monitoring the program and/or made recommendations if deemed necessary and appropriate.</p> <p>5. Client #2's medical record did not show evidence that the PCP had monitored the use of the CPAP machine since her annual medical evaluation on May 15, 2009. There was no evidence that the medical team sought information regarding alternative methods of treatment, to ensure timely response to her ongoing sleep apnea.</p> <p>It should be noted that in August 2009, the facility introduced the medication Trazodone as a sleep inducer without first documenting a review and</p>	{W 322}		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2010
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH 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
{W 322}	Continued From page 20 approval by the Client #2's medical guardian (see W124) and by its Human Rights Committee (see W263).	{W 322}		
{W 371}	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement an effective system to ensure each client participated in a self-medication training program, for three of the four clients in the sample. (Clients #2, #3 and #5)</p> <p>The findings include:</p> <p>On December 23, 2009, the facility submitted a POC to address condition level deficiencies cited during the November 19, 2009 survey. According to the POC, a self-medication administration assessment would be "completed and received annually by the RN. If the client is a candidate for self-medication, a program will be developed and implemented."</p> <p>1. On January 4, 2010, at approximately 7:27 a.m., the morning nurse was observed testing Client #2's blood glucose levels, via finger stick and glucometer. The client was diabetic and received finger sticks twice daily, in accordance with her physician's orders. That morning, the client did not participate in any of the steps, although she remained calm throughout the</p>	{W 371}		

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 6TH STREET NW WASHINGTON, DC 20011
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{W 371}	<p>Continued From page 21</p> <p>process. After the client left the room, interview with the nurse revealed that he thought Client #2 might be able to stick her own finger with the lancet and perhaps use the glucometer. He acknowledged that he had not asked her to try doing so and he stated that none of the clients in this facility had a self-medication training program.</p> <p>At approximately 12:01 p.m., review of Client #2's self-medication assessment, dated August 14, 2009 revealed that she was assessed at the skill level II, which required staff assistance/independence in the area of self-administration of medications. The assessment, however, did not indicate whether or not she was a candidate for self-medication training. In addition, the assessment did not assess her skills and abilities with respect to testing her own blood glucose.</p> <p>On January 5, 2010, at 12:41 p.m., the RN acknowledged that Client #2 had not been assessed for her ability to push pills out of blister packs and/or steps in the finger stick-blood glucose testing process. She further indicated that she had observed Client #2 participate to some extent in the past.</p> <p>2. Similarly, on January 4, 2010, at approximately 2:05 p.m., review of medical and habilitation records revealed self-medication readiness assessments for Clients #3 and #5. According to their assessments, Clients #3 and #5 were also at the skill level II, which required staff assistance/independence in the area of self-administration of medications. The assessment, however, did not indicate whether or not the clients were candidates for</p>	{W 371}	<p>1. A self-medication readiness assessment will include whether or not self-medication training is appropriate for Client #2, #3, and #5.</p> <p>2. Client #3 self-medication readiness assessment will be updated to include whether or not the individual is a candidate for self-administration of medication.</p>	<p>2/5/10</p> <p>2/5/10</p>
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{W 371}	Continued From page 22 self-medication training programs. This was confirmed through interview with the facility's Registered Nurse (RN) on January 5, 2010, at 11:38 a.m. The RN confirmed that self-medication programs had not been developed for Clients #3 and #5.	{W 371}		
{W 438}	It should be noted that when interviewed on January 4, 2010, at 2:25 p.m., the QMRP stated "I thought all of them had one." 483.470(g)(2) SPACE AND EQUIPMENT  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, interview and record review, the facility failed to teach clients to use and make informed choices about the use of dentures, for the one (of three) sampled clients who had been prescribed dentures. (Client #1)  The finding includes:  As indicated in the facility's Plan of Correction (POC), dated December 23, 2009, Client #1's interdisciplinary team (IDT) met for a case conference on November 20, 2009. Although the IDT recommended that she receive new dentures, to be followed with training on the maintenance and care of the dentures, the client's next appointment with the dentist was scheduled for January 12, 2010. Therefore, as of January 5,	{W 438}	Resident #1 no longer resides at this facility. She was discharged on 1/21/10.	2/1/10

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{W 436}	Continued From page 23 2010, this citation remained unresolved.	{W 436}		
{W 455}	<p>483.470(f)(1) INFECTION CONTROL</p> <p>Previously, the November 19, 2009 survey had revealed no evidence that Client #1's denture-care skills had been assessed. Her annual plan did not reflect any past or current denture-related goals or objectives. In addition, there was no evidence that the facility's QMRP monitored and coordinated her denture needs with the day program to ensure that she received necessary and appropriate support and/or training. Staff at home and at the day program, however, were indicating that Client #1 routinely removed her dentures and did not use adhesive when reinserting them after her meals.</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement infectious control procedures to prevent communicable infectious diseases, for two of the four clients in the sample. (Clients #2 and #5)</p> <p>The findings include:</p> <p>On December 23, 2009, the facility submitted a Plan of Correction (POC) to address condition level deficiencies cited during the November 19, 2009 survey. According to the POC, staff would receive adequate training on implementing</p>	{W 455}	<div style="border: 1px solid black; padding: 5px;"> <p>1. An in-service training was held on 1/14/10 on implementing infectious control procedures. Staff will continue to receive on-going infectious control training on a quarterly basis.</p> </div>	1/14/10

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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4314 8TH STREET NW WASHINGTON, DC 20011</b>
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(W 455)	<p>Continued From page 24</p> <p>Infectious control procedures to prevent communicable infectious diseases by December 24, 2009.</p> <p>1. Evening observations conducted on January 4, 2010, at 4:15 p.m., revealed Client #5 was observed to remove the trash bag from the trash can, pick up a piece a paper from underneath the trash bag, place it in the trash bag, and sat the trash bag back inside the trash can. Moments later, Staff #1 informed Client #5 that it was not time to take out the trash. Staff #1 then verbally prompted the client to come to the dining table to participate in table top activities (i.e. writing name, puzzles, etc.) The client came to the table without first washing her hands. At no time did Staff #1 encourage Client #5 to wash her hands. When interviewed at 5:05 p.m., Staff #1 acknowledged that she had not encouraged Client #5 to wash her hands, adding "that was my mistake."</p> <p>2. On January 4, 2010, at 4:19 p.m., Client #2 was observed to go into the refrigerator and grab a jug of milk. The client drank approximately two to three swallows from the jug before Staff #2 intervened. Moments later, Staff #2 placed the jug of milk on the kitchen countertop. The milk remained out of the refrigerator for the next 85 minutes. At 5:46 p.m., Staff #2 picked up the same jug from the countertop and began pouring milk into Client #1's cup. Staff #1 and the surveyor alerted Staff #2 that the milk had been sitting on the countertop from earlier. Staff #2 intervened before Client #1 drank from the cup. Interview with Staff #2 revealed that while she had received training on nutrition, she had not received additional training on infection control procedures.</p>	(W 455)	<p>2. Cross reference W455.1</p>	<p>1/14/10</p>
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{W 455}	Continued From page 25  Review of the staff in service training records on January 5, 2010, at approximately 12:40 p.m., confirmed that Staff #2 had not received training on Infection control. This was also acknowledged with the QMRP on the same day at approximately 12:50 p.m.	{W 455}		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2010
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH 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
(1 000)	INITIAL COMMENTS  A follow up licensure survey was conducted on January 4, 2010 and January 5, 2010, to verify the facility's compliance with deficiencies cited during the November 19, 2009 relicensure survey and incident investigation. Two residents remained in the sample from the previous survey and two new residents were added from a population of six females with various disabilities. The findings of the survey were based on observations in the home, interviews with residents and staff (direct care, nursing and administrative), as well as a review of clinical, administrative, and habilitative records, including a review of unusual incident reports.	(1 000)		
(1 000)	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 odors.  This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for six of six residents included residing in the facility. (Residents #1, #2, #3, #4, #5 and #6)  The findings include:  On January 5, 2010, at approximately 12:20 p.m., an environmental walk-through revealed that the deficiencies identified on November 19, 2009 had not yet been abated. Interior stairwells had not	(1 000)		

Health Regulation Administration

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

*Program Director*  
TITLE

2/4/10  
(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0052	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED  R 01/05/2010
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		
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(1 080)	Continued From page 1  been repainted. [Note: Most of the previous citations were located on the outside of the facility (see listing below).] The qualified mental rehabilitation professional stated that the repairs would be achieved once the cold, winter weather improved.  Previously, the November 19, 2009 deficiency report included the following:  An environmental inspection conducted on November 19, 2009, beginning at 11:10 a.m. revealed the following:  1. There was chipping paint on the upper stairwell;  2. There were water stains and chipping paint in the dining room above the window frame;  3. There was chipping paint in in Resident #4's bedroom;  4. The front porch had chipping and peeling paint on the floor;  5. There was chipping and peeling paint and rust on the metal banister on the front porch;  6. The green carpet on the front steps had a large tear (a potential trip hazard);  7. The porch had cob webs in the corners of the ceiling;  8. The wooden threshold at the base of the front door was worn and aged; and,	(1 080)	1. Upper stairwell will be repaired and painted.  2. All window frames with the dining room will be repaired and painted.  3. Resident #4's bedroom will be painted.  4. Chipped and peeling paint will be removed from the floor.  5. Metal bannister on the front porch will be painted.  6. Carpet on the front steps will be replaced.  7. Cob webs in corners of porch ceiling will be removed.	2/28/10  2/28/10  2/28/10  2/28/10  2/18/10  2/1/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2010
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(1 090)	Continued From page 2 9. one of the screens on the back screen door had a large tear (approximately 10 inches in length).  The qualified mental retardation professional (QMRP) confirmed the findings.	(1 090)	9. The back screen on the back door will be replaced.	2/28/10
(1 203)	3509.3 PERSONNEL POLICIES  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to document annual reviews of job descriptions for all employees, for four out of eleven staff. (Staff #2, #3, #5 and #6)  The findings include:  On January 4, 2010, at approximately 5:15 p.m., review of three signed documents that were presented confirmed that supervisors had not discussed the contents of job descriptions at least annually with all staff, as follows:  Staff #3 had received job description reviews on October 11, 2008 and December 16, 2009 (post-survey);  Staff #5 had received job description reviews on October 16, 2008 and November 18, 2009 (survey-driven);  Staff #2 had had received job description reviews on October 10, 2008 and December 16, 2009 (post-survey); and,  There was no job description presented for Staff	(1 203)	Staff #6's job description was reviewed on 11/18/09 and was presented to the surveyor on 1/5/10.	2/7/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 01/05/2010
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH 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
(1 203)	Continued From page 3 #8.	(1 203)		
	Previously, the November 19, 2009 deficiency report included the following:  Interview with the qualified mental retardation professional (QMRP) and review of the GHMRP's personnel files conducted on November 16, 2009, beginning at 12:05 p.m., revealed the GHMRP failed to provide evidence that the facility discussed the contents of job descriptions with all staff. It should be noted that the presented records did not include a job descriptions for Staff #3, #5 and #6.			
(1 206)	<b>3509.6 PERSONNEL POLICIES</b>  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 GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for two of the six nurses, and one of the ten consultants.	(1 206)	The two nurses' health certificates have been updated. The QMRP will obtain the one consultant's health certificate.	2/10/10

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{ 208 }	Continued From page 4  The findings include:  On January 4, 2010, at approximately 5:00 p.m., the qualified mental retardation professional (QMRP) presented five health certifications. The certificates were for the five staff that had been identified during the November 19, 2009 survey (Staff #1, #2, #3, #5 and #7). Review of the dates noted by the physician on all five health certificates confirmed that the examinations were performed after the November 2009 survey ended. The QMRP stated that there were no additional health inventories available for review at that time.  As of January 5, 2010, there was no evidence that the GHMRP ensured that the two nurses (Nurses #1 and #2) and one consultant (Consultant #1) had obtained an updated health screening/inventory.  This is a repeat deficiency.  _____  Previously, a licensure deficiency report dated August 21, 2008 included the following:  Review of the personnel records on August 20, 2008, beginning at 5:24 PM, revealed the following:  1. The health certificate/ inventory on file for the House Manager had expired on September 9, 2007.  2. There were no health certificates/ inventories made available for review for 2 of the 9 direct support staff (S3 and S4) as well as the	{ 208 }		

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(1 206)	Continued From page 5 consulting Occupational Therapist.  3. The health certificates/ inventories on file for an LPN (N2) and an RN (N1) had expired in March 2008.  4. The health certificate/inventory on file for the Nurse Coordinator/RN had expired on September 26, 2004.  5. The health certificates/ inventories on file for the consulting Physical Therapist and Pharmacist had expired in April 2008 and June 2007, respectively.  The November 19, 2009 deficiency report included the following:  Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on November 18, 2009, beginning at 12:06 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for five of the eleven staff (Staff #1, #2, #3, #5 and #7), two of the six nurses (Nurses #1 and #2) and one of the ten consultants (Consultant #1).	(1 206)		
(1 227)	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;	(1 227)		

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		
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{1 227}	Continued From page 6  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review current training in CPR and first aid, for three of the eleven staff.  The finding includes:  On January 4, 2010, at approximately 5:00 p.m., the qualified mental retardation professional (QMRP) presented two CPR certification cards. However, review of the two staff persons' names on the cards (Staff #5 and #7) revealed that neither one matched with the three staff persons identified in the November 19, 2009 deficiency report as needing CPR certification and/or first aid training (Staff #4, #6 and #8).  Previously, the November 19, 2009 deficiency report included the following:  Review of the personnel and training records on November 16, 2009, beginning at 12:08 p.m., revealed the GHMRP failed to provide documentation of staff training in cardiopulmonary resuscitation (CPR), for two of the eleven staff (Staff #4 and #6) and first aid training, for two of the eleven staff (Staff #4 and #8).	{1 227}	Staff #5 and #7 have obtained CPR certificate cards.	2/18/10
{1 232}	3510.5(i) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (i) Training of the residents in the maintenance of	{1 232}		

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		
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{1 232}	Continued From page 7 oral health and hygiene.  This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to teach residents to use and make informed choices about the use of dentures, for the one (of three) sampled residents who had been prescribed dentures. (Resident #1)  The finding includes:  Cross-refer to Federal Deficiency Report - Citation W436. Resident #1 had not returned to the dentist since the November 19, 2009 survey; therefore, she had not received her replacement dentures. The facility's Plan of Correction, dated December 23, 2009, indicated that Resident #1 and her support staff would receive appropriate training after she received the new dentures on January 12, 2010. As of January 5, 2010, however, this citation remained unresolved.  Previously, the November 19, 2009 deficiency report included the following:  During the November 16, 2009 Entrance Conference, at approximately 9:45 a.m., the house manager (HM) and qualified mental retardation professional (QMRP) stated that Resident #1 had prescribed dentures. The resident, however, reportedly left her dentures in a restaurant while on vacation the first week of October 2009. During a visit to Resident #1's day program, at 11:58 a.m., their program manager confirmed that the resident used dentures. She thought, however, that the dentures had not fit properly, saying "I'm not sure	{1 232}	Cross reference W436	2/1/10

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(1 232)	<p>Continued From page 8</p> <p>If they're too big or too small." She explained that while Resident #1 wore them upon arrival in the morning, she would remove them to drink water or eat. She further stated that the resident would put her dentures back into her mouth without applying denture adhesive. She never saw the resident bring adhesive with her to day program and did not know whether she had received training on correctly inserting the dentures.</p> <p>At 5:10 p.m. later that day, Resident #1 asked the surveyor if he would attend her meeting Friday. The HM, who was present at the time, explained that there was a case conference scheduled to discuss her dentures. It was not clear whether she would receive new dentures. At 5:12 p.m., the resident told the HM that she wanted her dentures replaced. Further interview with the HM revealed that she was unsure whether the resident's denture-maintenance skills had been assessed. Since she became HM in June 2009, she had only seen staff applying the adhesive (Polygrip). She too had seen the resident remove her dentures at meals. She did not know whether there was any adhesive left on the dentures when the resident put them back in afterwards. She thought perhaps the resident licked the adhesive off the dentures. She also confirmed that the resident did not take Polygrip with her to day program.</p> <p>Resident #1's interdisciplinary team had met on September 21, 2009 for her annual Individual Support Plan (ISP) meeting. On November 17, 2009 at 10:33 a.m., review of the ISP revealed that she had seen her dentist a year earlier, on November 26, 2008 and there was "no issue - continue to use Polygrip." For personal hygiene, the ISP indicated that staff were responsible for providing "reminders for thorough dental care."</p>	(1 232)		

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(1232)	<p>Continued From page 9</p> <p>Further review of her records, however, failed to show evidence that her denture-maintenance skills had been fully assessed. Her plan did not reflect any past or current denture-related goals or objectives.</p> <p>On November 17, 2009 at 4:16 p.m., review of Resident #1's dental records revealed that she had been to the dentist on October 22, 2008 for an "annual" evaluation. The dentist wrote the following: "Pt should wear adhesive (Polygrip) to secure dentures. This will assist her eating with the dentures. Apply 30 minutes before meals. Remove dentures and clean at night." Resident #1 returned to the dentist approximately 1 month later. On November 26, 2008, the dentist wrote "Pt should put Polygrip to lower denture before meals to eat comfortably and to secure the dentures. No other problems were found."</p> <p>The Registered Nurse, QMRP and HM were interviewed a few minutes later. The RN, who had worked in the facility since May 2009, stated that she had not assessed Resident #1's denture-care skills nor had she observed the resident apply adhesive or install the dentures into her mouth. The HM shared with the others what she had stated the previous evening: that she had seen staff apply the adhesive but not the resident, and that she suspected that the resident might lick the Polygrip off her gums and/or dentures. The HM thought the facility had been cited previously and had subsequently developed a denture-related training program. She and the QMRP agreed to seek relevant progress notes, assessments, training data or any other documentation. No additional information was presented before the survey ended two days later.</p>	(1232)			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		
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(I 232)	Continued From page 10  In summary, there was no evidence that the facility assessed Resident #1's denture-care skills and developed appropriate training. In addition, there was no evidence that the facility's QMRP monitored and coordinated her denture needs with the day program to ensure that she received necessary and appropriate support and/or training.	(I 232)		
(I 401)	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS  Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.  This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident had a comprehensive assessment that depicted her behavior management needs, for two of the six residents of the facility. (Residents #2 and #4)  The findings include:  1. On December 23, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited during the November 19, 2009 survey. According to the POC, the qualified mental retardation professional (QMRP) would consult with the psychologist about addressing Resident #2's behaviors of begging for money and exposing herself to men. The January 5, 2010 revisit revealed that, to date, the resident's behaviors continued and they had not been assessed by the psychologist, as follows:	(I 401)	1a. Cross reference W130	1/11/10

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(I 401)	Continued From page 11  a. On January 4, 2010, at 7:38 a.m., Resident #2 asked a nurse for \$3 after they had completed the morning medication administration. The nurse declined her request. After the resident left the room, he indicated that she had asked him for money approximately six weeks earlier. Later that day, at 3:12 p.m., Resident #2 was observed standing in the dining area with staff and peers after returning home from day program. She immediately walked over to this surveyor and asked for \$3, with no intervention from staff who was observed standing beside the resident. At 3:34 p.m., the resident asked the surveyor for \$3 dollars while standing in the kitchen area with staff. At 3:44 p.m. and 3:46 p.m., Resident #2 again asked the surveyor for \$3 without staff intervention.  Interview with the QMRP on January 5, 2010, at approximately 11:00 a.m., revealed that the psychologist had been made aware of Resident #2's money-begging behavior. To date, however, the psychologist had not fully assessed her. Further interview with the QMRP revealed that the resident's guardian was unavailable to meet with the interdisciplinary team before January 11, 2010.  b. Similarly, interview with the QMRP on January 4, 2010, at approximately 11:00 a.m. and again at 5:30 p.m. revealed that Resident #2's propensity to expose herself to men had not yet been assessed by the psychologist. Earlier that morning, at approximately 7:00 a.m., Resident #2's bedroom door remained wide open while a male nurse was in an adjacent room, other residents and staff were in the hallway outside of her bedroom and a male surveyor was in the facility. The resident laughed when the surveyor	(I 401)	1b. Cross reference W130	1/11/10

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(I 401)	Continued From page 12  observed that she was fully naked. [See Federal Deficiency Report - Citation W130]  2. The facility's POC to address deficiencies cited on November 19, 2009 indicated that the QMRP would obtain the findings of Resident #4's sexuality assessment that was reportedly performed on September 11, 2009. However, on January 5, 2010, at 10:28 a.m., interview with the QMRP revealed that the facility still had not obtained a copy of the September 11, 2009 assessment report. It should be noted, however, that a consultation form documented that Resident #4 had returned to the same sexuality clinician on December 30, 2009 for counseling.	(I 401)	2. Cross reference W214.2	1/8/10
(I 436)	3521.7(f) HABILITATION AND TRAINING  The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:  (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement an effective system to ensure each resident participated in a self-medication training program, for three of the four residents in the sample. (Residents #2, #3 and #5)  The findings include:  On December 23, 2009, the facility submitted a POC to address condition level deficiencies cited during the November 19, 2009 survey. According	(I 436)		



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(1 438)	Continued From page 14 that she had observed Resident #2 participate to some extent in the past.  2. Similarly, on January 4, 2010, at approximately 2:05 p.m., review of medical and habilitation records revealed self-medication readiness assessments for Residents #3 and #5. According to their assessments, Residents #3 and #5 were also at the skill level II, which required staff assistance/independence in the area of self-administration of medications. The assessment, however, did not indicate whether or not the residents were candidates for self-medication training programs. This was confirmed through interview with the facility's Registered Nurse (RN) on January 5, 2010, at 11:38 a.m. The RN confirmed that self-medication programs had not been developed for Residents #3 and #5.  It should be noted that when interviewed on January 4, 2010, at 2:25 p.m., the QMRP stated "I thought all of them had one."	(1 438)		
(1 500)	3523.1 RESIDENT'S RIGHTS  Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.  This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the	(1 500)		



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(I 500)	<p>Continued From page 16</p> <p>psychotropic medication regimen. That consent form did not reflect the use of Trazodone or indicate a therapeutic range for Thorazine and Depakote (both of which had been increased substantially, in terms of daily dosage).</p> <p>3. Also at approximately 10:45 a.m., review of Resident #3's medical and habilitation records showed no evidence that the facility had reviewed her health status and treatment needs/options with her guardian, and no written consent was found in her records. The QMRP said she would look for a signed consent form for Resident #3. When interviewed on January 5, 2010, at 9:45 a.m., the QMRP repeated what she had stated the day before, that the facility had not reviewed the residents' restrictive behavior support plans with their respective legal guardians after the November 19, 2009 survey.</p> <p>It should be noted that on December 23, 2009, the facility submitted a Plan of Correction (POC). Review of the POC, however, revealed that it failed to address the immediate need to contact the residents' legal guardians to review the potential risks and benefits associated with psychotropic medications and obtaining written consent for administering the medications.</p> <p>Previously, the November 19, 2009 findings had included the following:</p> <p>1. There was no evidence that the facility informed Resident #2 and her court appointed guardian of her health status and treatment needs, to include the potential risks and benefits associated with new psychotropic medications (or significant increases in dosage) and obtained</p>	(I 500)	<p>3. Cross reference W124.2</p>	2/28/10
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(1500)	<p>Continued From page 17</p> <p>written consent prior to administering the medications, as follows:</p> <p>Observation of the evening medication pass on November 16, 2009 revealed that Resident #2 received Depakote 1000 mg, Thorazine 400 mg, Trazodone 100 mg and Abilify 30 mg. During the entrance conference, the QMRP and HM had indicated that Resident #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The resident had a court appointed guardian to assist her in making healthcare decisions. The resident's medical records were reviewed on November 18, 2009 beginning at 11:38 a.m.</p> <p>Her physician's orders (POs) indicated that Trazodone 50 mg was first ordered on August 3, 2009, with the first dose documented on her Medication Administration Record (MAR) as administered the next evening (August 4, 2009). The Trazodone was then doubled to 100 mg daily, effective October 16, 2009.</p> <p>Resident #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 daily, effective October 17, 2009; and, an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.</p> <p>On November 18, 2009 at 2:53 p.m., the most recent consent form in Resident #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented)</p>	(1500)		



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(1 500)	Continued From page 10  On January 4, 2010, at approximately 11:45 a.m., observations and interview with the QMRP, revealed that there were no clothes or shoes in Resident #2's closet. The QMRP stated that on December 7, 2009, the facility's Human Rights Committee had reviewed and approved restriction of Resident #2's access to her clothes and shoes. She further stated that the case conference had not yet occurred because some members of the IDT had not been available. A case conference reportedly was scheduled for January 11, 2010.  Previously, the November 19, 2009 deficiency report included the following:  An environmental inspection was conducted on November 19, 2009 beginning at 11:10 a.m. During the inspection there were no clothes observed in Resident #2's bedroom closet. Interview with the house manager (HM), during the inspection, indicated that the resident's clothes were stored in the basement and the resident was given an outfit each evening to wear the following day. The HM further indicated that the resident "will throw her clothes in the trash can."  2. Based on observation, interview and record review, the facility failed to teach Resident #1 to care for and use prescribed dentures, as follows:  The finding includes:  As indicated in the facility's Plan of Correction (POC), dated December 23, 2008, Resident #1's interdisciplinary team (IDT) met for a case	(1 500)	2. Cross reference W436	2/1/10

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(1 500)	Continued From page 20  conference on November 20, 2009. Although the IDT recommended that she receive new dentures, to be followed with training on the maintenance and care of the dentures, the resident's next appointment with the dentist was scheduled for January 12, 2010. Therefore, as of January 5, 2010, this citation remained unresolved.  Previously, the November 19, 2009 survey had revealed no evidence that Resident #1's denture-care skills had been assessed. Her annual plan did not reflect any past or current denture-related goals or objectives. In addition, there was no evidence that the facility's QMRP monitored and coordinated her denture needs with the day program to ensure that she received necessary and appropriate support and/or training. Staff at home and at the day program, however, were indicating that Resident #1 routinely removed her dentures and did not use adhesive when reinserting them after her meals.  3. Based on interview and record review, the facility failed to ensure Resident #3's individual program plan (IPP) included training in activities of dental hygiene.  On December 23, 2009, the facility submitted a Plan of Correction (POC) in which they indicated that the QMRP would add a toothbrushing goal to Resident #3's IPP to address poor oral hygiene by January 8, 2010.  Interview with the QMRP on January 5, 2010, at 10:40 a.m., revealed that she had not added a	(1 500)	3. Cross reference W242	2/1/10

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(I 500)	Continued From page 21  toothbrushing goal to address Resident #3's poor oral hygiene (as indicated in the September 2009 dental consultation). Further interview with the QMRP revealed that Resident #3's toothbrushing goal would be added at the six (6) month quarterly review in February 2010.  Previously, the November 19, 2009 deficiency report included the following:  Resident #3 was diagnosed with gingivitis, plaque on the teeth and poor oral hygiene. There was no evidence, however that the QMRP developed and implemented a training program to address the resident's poor oral hygiene.  4. Based on interview and record review, the facility failed to ensure Resident #3's individual program plan (IPP) included training in activities of personal grooming/ hair care.  The facility's POC, dated December 23, 2009, also indicated that the QMRP "will consider adding on additional home goals to address grooming and hair care needs at the next quarterly review by January 24, 2010."  On January 5, 2010, at approximately 10:44 a.m., interview with the QMRP revealed that she was not going to add a hair care goal for Resident #3. Further interview with the QMRP revealed Resident #3 became "agitated when too much is placed upon her."  Previously, the November 19, 2009 deficiency report included the following:	(I 500)	4. Cross reference W242.2	2/1/10

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  R 01/06/2010
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH 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	
{1 500}	Continued From page 22  Resident #3 received total assistance from staff for combing and brushing her hair. It was a sought-after activity. There was no evidence, however, that the GHMRP developed and implemented a training program to teach her grooming/hair care skills.	{1 500}			