STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G255	A. BUILDING B. WING	10/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI-SERVICES	3037 BLADENSBURG ROAD, NE, WASHINGTON, District of Columbia, 20017

(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
E0000	Initial Comments A recertification survey was conducted at this facility from 10/28/2026 through 10/30/2026. A sample of two clients was selected from a census of three. The survey was conducted utilizing the focused fundamental survey process. The survey findings were based on observations, interviews, and reviews of client and administrative records.	E0000	Please start typing your responses here:	
W0000	INITIAL COMMENTS A recertification survey was conducted at this facility from 10/28/2026 through 10/30/26. A sample of two clients was selected from a census of three. The survey was conducted utilizing the focused fundamental survey process. The survey findings were based on observations, interviews, and reviews of client and administrative records.	W0000		
E0007	EP Program Patient Population CFR(s): 483.475(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. **	E0007		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/30/2026

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E0007	Continued from page 1 *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This STANDARD is NOT MET as evidenced by: Based on observations, interview, and record reviews, the facility's Emergency Preparedness Plan (EPP) and/or individualized Personal Emergency Preparedness Plan (PEPP) failed to accurately address each client's assessed mobility, adaptive equipment, dietary, and medical needs that placed the client at risk for the two sampled clients (Clients #1 and #2). Findings included: 1. On 10/29/2026 at 8:40 AM, the review of Client #2's Physician Order Sheet (POS) dated October 2026 revealed the following details: Dietary requirements of a low fat, low cholesterol, low sodium, gluten-free, puree diet with finely chopped texture provided if puree is refused; Adaptive equipment consisting of a wheelchair, gait belt, shower chair, gel cushion seat, neck pillow, TED compression stockings, sectional plate, and adult protective undergarment; and Allergy to cucumber On 10/29/2026 at 12:00 PM, the review of Client #2's PEPP dated 03/01/2026, revealed that the client's dietary needs were documented as a 1,500 calorie, low sodium, finely chopped diet, which did not reflect the current physician ordered diet.	E0007		

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E0007	Continued from page 2 Further review of the Clients PEPP revealed: The client's adaptive equipment was not fully identified. The PEPP listed only a wheelchair, gait belt, and shower chair; The client's allergy to cucumber was not documented; The client's current medications were not documented; and The PEPP indicated, "is able to ambulate quickly in times of emergencies." Further review of Client #2's Physical Therapy Quarterly Assessment indicated that the client had a non-ambulatory gait and that her wheelchair is the primary source of all mobility in the home and the community. During an interview on 10/29/2026 at 8:26 AM, Direct Support Professional # 4 confirmed that Client #2 is unable to walk and relies on her wheelchair for all mobility. 2. On 10/28/2026 at 12:10 PM, Client #1 was observed wearing a left foot brace. Observations during the evening medication administration on 10/28/2026 at 6:00 PM, Client #1 received the following medications: Quetiapine, Docusate Sodium, Divalproex, Calcium Carb and Systane eye drops. On 10/29/2026 at 11:00 AM, a review of Client #2's PEPP dated 12/02/2025 revealed that the plan did not include the clients prescribed medications or the client's left foot brace and associated adaptive equipment needs. During an interview on 10/29/2026, the Qualified Intellectual Disabilities Professional stated that she would revise the PEPP to include the client's medication and all her adaptive equipment.	E0007		

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E0039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and	E0039		

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E0039	Continued from page 4 emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community-based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E0039		

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E0039	Continued from page 5 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:	E0039		

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E0039	Continued from page 6 (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or	E0039		

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E0039	Continued from page 7 prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]:	E0039		

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E0039	Continued from page 8 (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or	E0039		

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E0039	Continued from page 9 man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.	E0039		

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E0039	Continued from page 10 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to conduct the required annual community-based full-scale exercise, or when a community-based exercise was not accessible, an individual facility-based functional exercise, to test the facility's emergency preparedness program for all clients residing in the facility. Findings included: On 10/28/2026 at 1:15 PM, a review of the facility's Emergency Preparedness Program documentation revealed no evidence that the facility had conducted the required annual community-based full-scale exercise within the previous 12 months. Further review of the emergency preparedness records revealed no documented evidence that an individual facility-based functional exercise had been conducted in lieu of a community-based full-scale exercise. On 10/30/2026 at 3:50 PM, during the exit interview, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged that the facility failed to ensure participation in a community-based full-scale exercise.	E0039		
W0186	DIRECT CARE STAFF CFR(s): 483.430(d) (1-2) The facility must provide sufficient direct care staff	W0186		

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W0186	Continued from page 11 to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the availability of adequate Direct Support Professional (DSP) staffing to provide the required one-to-one supervision outlined in the clients' Physician Orders Sheet (POS) and Behavior Support Plan (BSP) for one of the two clients in the sample (Client #1). Findings included: The review of Client #1's BSP dated 01/06/2026 showed a restrictive component requiring a medical one-to-one staff support dedicated solely to assist the client. The BSP required that the one-to-one supervision should remain in place until the primary care physician determined that the support is no longer needed. Further review of Client #1's POS dated August 2026 revealed an order for a "Medical one-to-one support staff, 16 hours per day, seven days a week." Observations on 10/28/2026 from 2:38 PM through 3:10 PM showed DSP #1 in the kitchen preparing dinner for the evening shift, while Client #1 sat alone in the dining room without the required one-to-one staff supervision. DSP #1 when asked about the clients one-to-one supervision indicated that she was preparing dinner for the evening shift. At 2:58 PM, DSP #1 provided Client #1 with a mug of ice cream and returned to the kitchen and continued with the meal preparations. Client #1 remained in the dining room and stirred the ice cream until DSP #1 returned after preparing the evening meal. During an interview on 10/29/2026 at 12:30 PM, the	W0186		

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W0186	Continued from page 12 Qualified Intellectual Disabilities Professional confirmed that Client #1 required one-to-one supervision 16 hours per day, as specified in the POS and BSP.	W0186		
W0194	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(4) 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. This STANDARD is NOT MET as evidenced by: Based on observations, interview, and record reviews, the facility failed to ensure Direct Support Professionals (DSP) demonstrated competency in implementing each client's Behavior Support Plan (BSP) for one of the two clients in the sample (Client #1). The review of Client #1's BSP dated 01/06/2026 identified physical aggression as a targeted behavior. The BSP outlined the following intervention strategies: If become physically aggressive, do not become involved in an exchange of words. Encourage her in a calm voice to calm down. If her behaviors escalate or is she balls up her fist, grabs, spits, or attempts to hit, firmly ask her to stop. Staff should increase the distance between the Remind that you will listen to her when she stops attempting to harm another. Offer a change of environment. Once the client has discontinued the behavior, staff should allow time to listen to her concerns and remind her of the appropriate behavior for home or other environment/settings. The BSP further required staff support to assist with ambulation, monitor behaviors, implement BSP interventions, document behaviors, redirect	W0194		

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W0194	Continued from page 13 aggressive and self-injurious behaviors. During the medication administration observations on 10/28/2026 at 6:00 PM, Client #1 struck the surveyor in the abdomen, while DSP #7 who was present failed to intervene in accordance with the BSP. Minutes later, Client #1 again hit and pushed the surveyor in the abdomen, and DSP #7 responded by asking the client to stop and rubbed the clients shoulders. During an interview on 10/28/2026 at 7:00 PM, DSP #7 stated that Client #1 becomes aggressive when visitors are in the home or when they are in a crowded environment. On 10/29/2026 at 12:30 PM, the Qualified Intellectual Disabilities Professional acknowledged in an interview that DSP #7 should have implemented and documented the interventions required by the BSP.	W0194		
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 observations, interviews and record reviews, the facility failed to properly implement each client's Behavior Support Plan (BSP) for one of the two clients in the sample (Client #1). 1. The review of Client #1's BSP dated 01/06/2026 identified physical aggression as a targeted behavior. The BSP outlined the following intervention strategies: If the client becomes physically aggressive, do not become involved in an exchange of words. Encourage her in a calm voice to calm down. If her behaviors escalate or if she balls up her fist, grabs, spits, or attempts to hit, firmly ask her to stop. Staff should increase the distance between the	W0249		

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W0249	Continued from page 14 and any peer or staff member that might be present. Remind that you will listen to her when she stops attempting to harm another. Offer a change of environment. Once the client has discontinued the behavior, staff should allow time to listen to her concerns and remind her of the appropriate behavior for home or other environment/settings. The BSP further required staff support to assist with ambulation, monitor behaviors, implement BSP, document behaviors, redirect aggressive and self-injurious behaviors. Observations during the medication administration pass on 10/28/2026 at 6:00 PM, showed that Client #1 struck the surveyor in the abdomen, and DSP #7 failed to intervene in accordance with the BSP. Minutes later, Client #1 again hit and pushed the surveyor in the abdomen, and DSP #7 responded by asking the client to stop and rubbed the clients shoulders. During an interview on 10/28/2026 at 7:00 PM, DSP #7 stated that Client #1 becomes aggressive when visitors are in the home or when they are in a crowded environment. On 10/29/2026 at 12:30 PM, the Qualified Intellectual Disabilities Professional in an interview apologized for Client #1's behavior and confirmed that DSP #7 should have implemented and documented the interventions required by the BSP. 2. The review of Client #1' physician order sheet (POS) dated August 2026 indicated that the Client required a wheelchair for mobility. On 10/29/2026 at 12:45 PM, the review of Client #1's feeding protocol dated 03/13/2026 revealed that staff were to feed the client while seated in a regular chair, "unless in behavior". Observations during lunch on 10/28/2026 at 12:06 PM showed that Client #1 received lunch while seated in a wheelchair, and also during snack at 3:00 PM. There was no evidence during either observation that Client #1 exhibited behaviors that would require	W0249		

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W0249	Continued from page 15 implementation of the exception identified in the feeding protocol. DSP #1 during an interview on 10/30/2026, DSP #1 stated that Client #1 requires transfers to the toilet and bed but “eats in her wheelchair.”	W0249		
W0252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) 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 observations, staff interviews and record reviews, the facility failed to document each client’s physical aggression behavior in a form and frequency as required by the Behavior Support Plan (BSP) for one of the two clients in the sample (Client #1). Findings Included: The review of Client #1’s BSP dated 01/06/2026 identified physical aggression as a targeted behavior. The BSP outlined the following intervention strategies: If become physically aggressive, do not become involved in an exchange of words. Encourage her in a calm voice to calm down. If her behaviors escalate or is she balls up her fist, grabs, spits, or attempts to hit, firmly ask her to stop. Staff should increase the distance between And any peer or staff member that might be present. Remind that you will listen to her when she stops attempting to harm another. Offer a change of environment. Once the client has discontinued the behavior, staff should allow time to listen to her concerns and remind her of the appropriate behavior for home or other environment/settings.	W0252		

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W0252	Continued from page 16 The BSP further required staff support to assist with ambulation, monitor behaviors, implement BSP, document behaviors, redirect aggressive and self-injurious behaviors. Observations during the medication administration on 10/28/2026 at 6:00 PM, showed that Client #1 struck the surveyor in the abdomen, while Direct Support Professional (DSP) #7 present failed to intervene in accordance with the BSP. Minutes later, Client #1 again hit and pushed the surveyor in the abdomen and DSP #7 responded by asking the client to stop and rubbed the clients shoulders. During an interview on 10/28/2026 at 7:00 PM, DSP #7 stated that Client #1 becomes aggressive when visitors are in the home or when they are in a crowded environment. In an interview on 10/29/2026 at 12:30 PM, the Qualified Intellectual Disabilities Professional apologized for Client #1's behavior and confirmed that DSP #7 should have implemented and documented the interventions required by the BSP.	W0252		
W0381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of security. This STANDARD is NOT MET as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to ensure that drugs were stored under proper conditions of security for two of the three clients in the facility (Clients #1 and #2). Findings Included: The review of a facility policy titled, "Medication Storage Policy" dated 03/27/2026 listed the following procedures: Medications must be stored according to the package insert in a locked medication cabinet or medication refrigerator with sufficient storage space The medication cabinet and medications refrigerator must be locked when not in use	W0381		

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W0381	Continued from page 17 Nursing staff and trained medication employees are responsible for safeguarding the keys and combination codes for the medication cabinet, medication refrigerator, or both On 10/28/2026 at 6:00 PM, Licensed Practical Nurse (LPN) was observed preparing medications for Client #2 and then taking the medication to the client's bedroom. When the LPN left the medication room, the medication cabinet drawers were left wide open and unsecured. During that time, DSPs #5 and #6 and surveyors were observed moving throughout the facility and had potential access to the unsecured medication storage area. Upon returning to the medication room, the LPN acknowledged that the medication cabinet drawers were left unsecured. Review of the personnel records on 10/29/2026 beginning at 12:03 PM showed that DSP's #5 and #6 did not have Trained Medication Employee certifications documented in their personnel files.	W0381		
W0426	CLIENT BATHROOMS CFR(s): 483.470(d)(3) The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure that water temperatures exceeded 110 degrees Fahrenheit (°F) for the three clients residing in the facility (Clients #1, #2 and #3). Findings included: The review of a facility policy titled "Procedures for Maintaining Hot Water Temperature" indicated that water temperature within the facility will be maintained at a minimum of 100 °F and maximum of 110 °F by Maintenance Team including Evening Managers.	W0426		

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W0426	Continued from page 18 The policy listed the following procedures: Water temperature control setting will be turned down by Maintenance Team/Evening Manager to measure maximum 110 °F and minimum 100 °F. The water temperature will be taken two times daily using the hot water temperature checklist for three consecutive days. If hot water continues to remain inconsistent after three days will purchase a hot water mixing valve to stabilize the water temperature between 100 °F and 110 °F. Observations on 10/28/2026 at 2:25 PM, during handwashing in the staff bathroom, showed that the water felt warm to the touch. At 2:35 PM, the water temperatures were measured in Client #1 and #2's bathroom and in the kitchen measuring at 113 °F and 114.5 °F, respectively. Again on 10/29/2026 at 11:30 AM, the water temperatures were measured and revealed the following: kitchen measured 114.2 °F and Clients #1 and #2's bathroom measured 114.1 °F. During the environmental inspection on 10/30/2026 at 1:25 PM, accompanied by the Qualified Intellectual Disabilities Professional (QIDP), the water temperatures measured 113.2 °F in the kitchen and 113 °F in Client #1 and #2's bathroom. A request was made to the QIDP for the facility's water temperature checklist. By the conclusion of the survey, no water temperature checklist was provided. The QIDP acknowledged the elevated temperatures and stated she would contact maintenance personnel to adjust the water heater system.	W0426		
W0455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W0455		

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W0455	Continued from page 19 This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure that oral hygiene supplies were maintained in a sanitary manner for one of the two sampled clients (Client #1). Findings included: Observations on 10/30/2026 at 1:26 PM, during an environmental walkthrough of Client #1's bedroom, showed a toothbrush stored upright in a cup on the client's dresser. The toothbrush was uncovered and the bristles appeared worn and frayed. During an interview on 10/30/2026 at 1:28 PM, Qualified Intellectual Disabilities Professional confirmed the toothbrush belonged to Client #1 and acknowledged the toothbrush was worn and stored uncovered.	W0455		
W0460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially prescribed diets. This STANDARD is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure that each client received specially prescribed diet as ordered for one of the two sampled clients (Client #2). Findings included: A review of Client #2's Physician Order Sheet (POS) dated October 2026, revealed a dietary order of a low fat, low cholesterol, low sodium, gluten free, puree diet and if pureed texture is refused provide finely chopped texture. Observation on 10/28/2026 at 12:30 PM, showed Direct Support Professional #2, feeding Client #2 a peanut butter and jelly sandwich and strawberry yogurt. An inspection of the bread packaging revealed that the bread contained gluten which is inconsistent with Client #2's physician ordered gluten free diet.	W0460		

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W0460	Continued from page 20 In an interview on 10/29/2026 at 12:00 PM, DSP #4 stated that Client #2's lunch had consisted of a deli sandwich, macaroni salad, and applesauce. Inspection of the product labels revealed the ham contained 550 milligrams (mg) of sodium per serving, and the macaroni salad contained 630 mg of sodium per serving. It should be noted that these food items were inconsistent with Client #2's physician ordered low sodium diet. During an interview on 10/29/2026 at 12:36 PM, the Qualified Intellectual Disabilities Professional confirmed that Client #2 is on a prescribed gluten free diet and acknowledged the above findings.	W0460		