STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G024	A. BUILDING ______ B. WING ______	06/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 06/25/18 through 06/27/18. A sample of two clients was selected from a population of four women with varying degrees of intellectual disabilities. This survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. DON - Director of Nursing DSP - Direct Support Personnel LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to provide infection control procedures during wound care for one of two clients in the sample (Client #1). Findings included: On 06/26/18, starting at 8:29 AM, after Client #1's	W 339	The Director of Nursing will develop wound care protocol and train nursing staff on the protocol and infection control. DON will monitor for compliance quarterly.	9/25/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese (signature) TITLE: Program Director (handwritten) (X6) DATE: 9/25/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 339	Continued From page 1	W 339		

medication administration, the RN instructed Client #1 to remove her shoes and socks to prepare for wound care. The client was observed to take off her shoes, exposing multiple open wounds on both of her feet. The client was observed several times picking the open areas with her hands then placing her hands on the arms of the chair where she sat. It should be noted that the chair used was for each client's medication administration, as well as for general office use.

The client placed one foot on top of her shoe, and the other on the carpeted floor. Client #1's shoes were observed to be stained with blood. When asked by the surveyor if the client always placed her feet on her shoes during wound care, the RN stated, "we can maybe use a paper towel", then requested that DSP #6 bring paper towels to the room. The nurse further stated that the facility did not have any other protective pads in the facility.

Minutes later, DSP #6 arrived back to the medication room with two (2) paper towels, and placed them over Client #1's shoes. The client then placed her feet on the paper towels. The RN proceeded to clean and dress the client's right foot. Then, the RN moved a small trash can closer to Client #1. The RN propped the client's left foot on the trash can and cleaned the wounds. The RN removed the client's foot from the trash can at the surveyor's request and continued to clean and dress Client #1's left foot.

At 8:48 AM, the RN stated that the facility does not have a wound care policy, but she always followed the physician's wound care orders. The nurse further stated that the chair would be cleaned before the next client received

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W 339	Continued From page 2 medications. At 1: 25 PM, interview with the DON revealed that Client #1 had a targeted behavior of skin picking for many years, which often led to open wounds, however, the agency did not have a wound care policy. The DON stated that the nurses were to follow the physician's wound care orders and use universal precautions. On 06/27/18, review of the facility's inservice training records revealed the most recent training for infection control was 03/17/17. However, the RN's name did not appear on the sign-in sheet.	W 339	The identified RN will receive additional training on infection control when providing wound care.	8/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0085	A. BUILDING: ______ B. WING ______	06/27/2018

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I 000	INITIAL COMMENTS	I 000		

A licensure survey was conducted from 06/25/18 through 06/27/18. A sample of two residents was randomly selected from a population of four women with varying degrees of intellectual disabilities.

The findings of the survey were based on observations, interviews and review of resident and administrative records.

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

DON - Director of Nursing
DSP - Direct Support Professional
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered nurse

I 401 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS — I 401

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

This Statute is not met as evidenced by:
Based on observation, interview and record review, the facility's nursing services failed to provide infection control procedures during wound care for one of two clients in the sample (Resident #1).

Findings included:

On 06/26/18, starting at 8:29 AM, after Resident

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0085	A. BUILDING: ______ B. WING ______	06/27/2018

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I 401	Continued From page 1 #1's medication administration, the RN instructed Resident #1 to removed her shoes and socks to prepare for wound care. The resident was observed to take off her shoes, exposing multiple open wounds on both of her feet. The resident was observed several times picking the open areas with her hands then placing her hands on the arms of the chair where she sat. It should be noted that the chair used was for each resident's medication administration, as well as for general office use. The resident placed one foot on top of her shoe, and the other on the carpeted floor. Client #1's shoes were observed to be stained with blood. When asked by the surveyor if the resident always places her feet on her shoes during wound care, the RN stated, "we can maybe use a paper towel", then requested that DSP #6 bring paper towels to the room. The nurse further stated that the facility did not have any other protective pads in the facility. Minutes later, DSP #6 arrived back to the medication room with two (2) paper towels, and placed them over Resident #1's shoes. The resident then placed her feet on the paper towels. The RN proceeded to clean and dress the resident's right foot. Then, the RN moved a small trash can closer to Resident #1. The RN propped the resident's left foot on the trash can and cleaned the wounds. The RN removed the resident's foot from the trash can at the surveyor's request and continued to clean and dress Resident #1's left foot. At 8:48 AM, the RN stated that the facility does not have a wound care policy, but she always followed the physician's wound care orders. The nurse further stated that the chair would be	I 401	The Director of Nursing will develop wound care protocol and retrain all nursing staff on the protocol and infection control. DON will monitor for compliance quarterly.	9/25/18

Health Regulation & Licensing Administration

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I 401	Continued From page 2 cleaned before the next resident received medications. At 1: 25 PM, interview with the DON revealed that Resident #1 had a targeted behavior of skin picking for many years, which often led to open wounds, however, the agency did not have a wound care policy. The DON stated that the nurses were to follow the physician's wound care orders and use universal precautions. On 06/27/18, review of the facility's inservice training records revealed the most recent training for infection control was 03/17/17. However, the RN's name did not appear on the sign-in sheet.	I 401	The identified RN will receive additional training on infection control when providing wound care.	8/10/18

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E 000	Initial Comments An emergency preparedness survey was conducted from 06/25/18 through 06/27/18. The findings of the survey were based on interviews and review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. CP - Communication Plan ED - Executive Director EP - Emergency Plan EPP - Emergency Preparedness Plan ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities PEP - Personal Emergency Plan QIDP - Qualified Intellectual Disabilities Professional RA - Risk Assessment	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.	E 006	The facility will update the Risk Assessment to address all hazards that are indentified as a significant threat to include a missing person policy. The policies will be reviewed annually and updated by the Program Director. Staff will receive additional training.	9/25/18 9/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese
TITLE: Program Director
(X6) DATE: 9/25/18

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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E 006	Continued From page 1	E 006		

*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

(2) Include strategies for addressing emergency events identified by the risk assessment.

* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure that facility-based and community-based risk assessment included strategies to address missing persons, for four (4)of 4 clients residing in the facility (Clients #1, 2, 3, and 4).

Findings included:

On 06/27/18 beginning at 12:05 PM, interview with the QIDP showed that the facility's RA identified naturally occurring, technological, and human-related events as potential threats to the client health and safety. During the aforementioned interview, the QIDP did not mention "missing persons" as a potential hazard.

On 06/27/18 at 12:39 PM, review of the facility's RA included in the EP dated 01/07/18, however, showed the third highest relative human-related event (39%) was "missing persons". The PEP for each of the four clients and facility's EP (dated 1/07/18) documented no evidence that the facility

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	09G024	A. BUILDING ______ B. WING ______	06/27/2018

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E 006 Continued From page 2 — E 006

had established a plan for missing persons.

During a follow-up interview on 06/27/18 at 1:15 PM, the EP coordinator acknowledged that the policies and procedures still need to be developed to address missing persons.

At the time of the survey, there was no evidence that the facility completed the RA for the development of the EP to address all hazards identified as a significant threat (missing persons).

E 015 Subsistence Needs for Staff and Patients — E 015

CFR(s): 483.475(b)(1)

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 (B) Emergency lighting.
 (C) Fire detection, extinguishing, and alarm

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E 015	Continued From page 3 systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies and procedures to ensure subsistence needs (specifically sewage and waste disposal) during emergency situations, for four (4) of 4 clients residing in the facility (Clients #1, 2, 3, and 4). Findings included: On 06/27/18 at 12:45 PM, review of the facility's EP dated 01/07/18 showed no evidence that policies and procedures included measures to address sewage and waste disposal.	E 015	The policy for Water/Sewage and Waste Disposal was developed and staff will receive training by Management. The policy will be reviewed annually by the Program Director	9/25/18

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E 015	Continued From page 4 During an interview on 06/27/18 at 1:15 PM, the EP Coordinator stated that she was investigating measures to manage sewage and waste in the event of an emergency. She confirmed, however, that the current EP did not include policies and procedures for sewage and waste disposal services. At the time of the survey, there was no evidence that the facility's policies and procedures addressed all subsistence needs, such as sewage and waste disposal during emergency situations.	E 015		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care	E 026		

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E 026	Continued From page 5 at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures that describe its role in providing care during major disasters or federal emergencies, for four (4) of 4 clients residing in the facility (Clients #1, 2, 3, and 4). Findings included: On 06/27/18, at 12:29 PM, review of the facility's emergency plan dated 01/07/18 showed no evidence that the facility developed policies and procedures to address the role of the facility under a waiver declared by the Secretary of Health and Human Services (public health emergencies) or in the provision of care and treatment at an alternate care site identified by emergency management officials when the President of the United States, in accordance with section 1135 of the Stafford Act, declares a major disaster or emergency. On 06/27/18, at 1:25 PM, the QIDP said he was aware of the 1135 waiver provisions, however the specifics of the facility's role were not included in the policies and procedures. The EP coordinator stated during a follow-up interview at 4:40 PM, that the agency was in the process of developing policies and procedures to include the facility's role in emergencies declared by the Secretary of Health and Human Services or when the President declares a major disaster or emergency under the Stafford Act. At the time of the survey, there was no evidence that the facility's EP addressed the provision of	E 026	In the event of a National Emergency, Community Multi-Services, Inc. will follow the Federal Plan listed under section 1135 for continued operation. An identified alternate site will be utilized during a National Emergency. The Program Director will follow the instructions given by Federal/State government officials and request services from specific volunteer groups to assist us whenever needed. (Medical Reserve Corp/Citizen Corp Program & Partners/neighborhood Watch)	9/25/18

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

PRINTED: 07/31/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 026	Continued From page 6 care at alternate sites during national emergencies.	E 026		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030	The facility's communication plan will maintain a list of the names and contact information for consultants who can assist during an emergency. The Program Director will review contact information daily.	9/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 030	Continued From page 7 (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a CP that included the names and contact information of the physician and other consultants, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 06/27/18, beginning at 2:36 PM, review of the facility's EP (dated 01/07/18) and CP (dated 01/07/18) showed no evidence that the facility had developed a current list of consultants names and their and contact information. On 06/27/18, at 4:40 PM, the emergency	E 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G024	A. BUILDING ______ B. WING ______	06/27/2018

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E 030	Continued From page 8 preparedness leader acknowledged during a follow-up interview that the contact information for the physician and other consultants was kept on file at the facility, however, needed to be included in the facility's CP. At the time of the survey, there was no evidence that the facility's CP included the name and contact information for the physician and other consultants as required.	E 030		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the CP described the method used for sharing its EPP and policies with each clients' involved family member or representative, for four (4) of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 06/27/18, at 11:36 AM, review of the facility's EPP (dated: 01/07/18) showed no information regarding the sharing of the EPP and related policies with involved family members or	E 035		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 035	Continued From page 9 representatives. On 06/27/18, at 1:15 PM, interview with the EP coordinator showed the clients' families and/or representatives should have already been told about the facility's new emergency preparedness program. Follow-up with the QIDP revealed that the clients' families and/or representatives had been provided information on the emergency plans in effect before the new plan was developed in November 2017. The QIDP stated, however, that the clients' families and/or representatives, and the interdisciplinary team would provide information on the requirements of the new EPP during the six-month reviews and the annual individual support plan meetings, whichever occurs first. At the time of the survey, there was no evidence that the facility developed written guidance regarding the method(s) to be used for sharing information regarding the emergency plan with the clients' families or representatives.	E 035	The facility will develop a written plan for the EPP that will contain methods within the Communication Plan that will give guidance for sharing information for the client's families or representatives during an emergency. The Program Director will review plan annually.	9/25/18