DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/08/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BUILDING 09G062 B. WING 02/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 000 INITIAL COMMENTS W 000 A recertification survey was conducted from 02/13/19 through 02/15/19. Three clients were selected from a population of six women with intellectual disabilities. A fourth person, Client #6, was added for a focused review of the client's staffing and behavior support needs. This survey was conducted using 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. BMI - Body Mass Index BSP - Behavior Support Plan DSP - Direct Support Professional IPP - Individual Program Plan lbs - pounds LPN - Licensed Practical Nurse POS - Physician's Order Sheets QIDP - Qualified Intellectual Disabilities Professional °F - Degree Fahrenheit W 252 PROGRAM DOCUMENTATION W 252 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: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (XII) DATE sum 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 discidsable 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

FORM CMS-2587(02-99) Previous Versions Obsolete

program participation.

Event ID: BOJW11

Facility ID: 09G062

If continuation sheet Page 1 of 7

PRINTED: 03/08/2019

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		09G062	B. WING		02/	15/2019
NAME OF	PROVIDER OR SUPPLIER	W. W	"	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0 1117	10/2015
COMMU	NITY MULTI SERVICE	S, INC		WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	review, the facility far maladaptive behavior accordance with ear clients residing in the Findings included: On 02/13/18 at 5:31 showed the following: - At 5:32 PM, Client: and biting her wrist will living room. DSP #1 activities such as wathe radio. At 5:36 PM began playing with Limat on the floor. - At 5:46 PM, Client: a the chair, began shrid DSP #1 offered her a listening to the radio again. The client was more quickly this time. At 5:49 PM, Client: a leaned forward in the assisted the client to a Lego piece, calmly then got back into the eased that the LPN winedications upstairs.	ion, interview and record ailed to ensure that each or was documented in ch client's BSP, for one of six e facility (Client #6). PM, evening observations g: #6 began shrieking loudly while seated in a chair in the offered her a variety of alking or changing stations on alking or changing stations on each of the egos (a favored activity) on a seriety of activities such as or playing with the Legos is observed to calm down each echair. DSP #1 immediately the floor. Client #6 picked up handed it to DSP #1 and	W 25	Staff will receive additional trainow to properly document Clie maladaptive behavior on client behavior data sheets on every by psychologist. During observed behavior, management will rerito document. QIDP/ Res. Mgr/QA & Night Supervisor will monitor for compliance.	ent #6 t's shift /ation o	of

- At 5:56 PM, Client #6 shrieked and bit her wrist.

client.

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVI
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T (X2) MULTI	PLE CONSTRUCTION	OMB NO. 0938-03
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SURVEY COMPLETED
		09G062	B. WING_		02/15/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2010
COMMU	NITY MULTI SERVICE	S, INC		WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OUD BE COMPLETIO
	dismissive way towal LPN walked away. E and asked the client calmed down. On 02/14/19 at 10:00 behavior data sheets the behaviors observabetween 5:32 PM and documented. On 02/14/19 at 10:40 screaming and wrist targeted behaviors in have been document stated that she would was upstairs in the fa	an flicking her wrist in a and the LPN and DSP #1, the DSP #1 turned on the radio to select a station. The client DAM, review of Client #6's showed no evidence that yed on the previous evening	W 252	The facility's psychologist wi	ll provide
c t	acknowledged to her document the behavio	that she had failed to ors on the day before and late entries on the client's		training to DSP#1 and staff of importance of documenting (target behaviors.	on the Client #6 3/21/19
1 b	2/05/18, confirmed the iting were among the	Client #6's BSP, dated nat screaming and wrist targeted behaviors and ment all target behaviors.			1
in co #(si	5's BSP on 12/12/18.	ords showed that the standard trained staff on Client			
er	isure that Client #6's	ey, the facility failed to targeted behaviors of ting were documented in			

CENTERS FOR MEDICAL	RE & MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTI A. BUILDIN	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
N	09G062	B. WING_		02/15/2019
NAME OF PROVIDER OR SUPPLIE	R	1	STREET ADDRESS, CITY, STATE, ZIF	, CODE
COMMUNITY MULTI SERVICE	CES, INC		WASHINGTON, DC 20011	
PRÉFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION OF THE CORRECTIVE ACTION OF	ON SHOULD BE COMPLÉTIO REAPPROPRIATE DATE
W 252 Continued From p	page 3	W 25	2	
accordance with t				
W 426 CLIENT BATHRO		W 420	⁶ Water temperature will	ha manitared
CFR(s): 483.470(d)(3)		and recorded daily to e	neura that
The facility rough i	n orong of the facility where		water temperature does	
clients who have r	n areas of the facility where not been trained to regulate		110 degrees fahrenheit	. 2/15/19
water temperature	are exposed to hot water,		William Section 1	
ensure that the ter	mperature of the water does not			
exceed 110 degre	es Fahrenheit.			
Based on observa	is not met as evidenced by: ation and interview, the facility at the water temperature did			
not exceed 110°F,	for six of six clients residing in 11, 2, 3, 4, 5 and 6).			
Findings included:				1
During the environment 12:22 PM water	mental inspection on 02/15/19, from the faucet of the			
bathroom sink was	hot to touch. When			9.
measured, the wate	er temperature was			
determined to be 1	14°F. Continued inspection of			
hathrooms also rov	econd floor sinks and ealed hot water that exceeded			*
110°F as evidenced	by the following:			*
	a by the tenething.		9	i
Kitchen faucet - 114				*
First floor bathroom Second floor bathro				i
Georgia noor battiito	OH - 14 F			
	DP was interviewed at 12:25			į.
PM, concerning the	hot water temperatures. The			8
QIDP acknowledge	that the water was hot and			1
According to the OU	red temperature of 110°F. DP, three of six clients (Client			14
#1, 2, and 5) have a	daptive and cognitive			21

		& MEDICAID SERVICES			OMB NO. 0938-039
STATEME AND PLAI	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		09G062	B. WING_		02/45/2040
NAME O	F PROVIDER OR SUPPLIER		, T	STREET ADDRESS, CITY, STATE, ZIP CODE	02/15/2019
COMM	UNITY MULTI SERVICE			WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 426	○ Continued From pa	ne 4	144.40		,,
		ol water temperatures.	W 42		
				The facility's water temperat checked daily and recorded	to ensure
	Upon immediate notification of the hot water temperature on 02/15/19, the QIDP reported to the maintenance employee to check the water temperatures. The maintenance employee indicated that the water temperature would be			that the water temperature of	loes not
				exceed 110 degrees fahrent	neit.
				QIDP/Maintenance Team wi for compliance.	3/15/19
	turned down to achie	eve the 110°F for safety.		or complained.	3/13/18
		and the second second and the second			i i
	surveyor and the ma the hot water temper	oximately 4:00 PM, the intenance employee checked ratures again, which revealed			į.
	the following:				8
	Kitchen faucet - 110° First floor bathroom - Second Floor bathroom	109°F			Ů.
					20
	At the time of survey,	the facility failed to ensure			and the second
W 440	EVACUATION DRILL CFR(s): 483.470(i)(1)		W 440		í
	The facility must hold	evacuation drills at least			31 1
	quarterly for each shift	n or personnel.			i
	make the company of t				- 1
	Based on interview a failed to hold evacuati the six shifts of duty re	not met as evidenced by: nd record review, the facility on drills quarterly, for two of eviewed (weekend 4:00 PM			164
	- 12:00 AM and 12:00	AM - 8:00 AM).			
	Findings included:				
1	the QIDP revealed tha	, at 3:16 PM, interview with t there were three DAM - 4:00 PM; 4:00 PM -			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO

	ELITO I OIT WILLOTO INTE	A MILDIONID OLIVOIDE	116		OMR M	O. 0938-039
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG	(X3) D.	ATE SURVEY OMPLETED
		09G062	B. WING		0	2/15/2019
	F PROVIDER OR SUPPLIER UNITY MULTI SERVICE	S, INC		STREET ADDRESS, CITY, STATE, ZIP (WASHINGTON, DC 20011	CODE	2110/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
W 440	through Friday and AM - 4:00 PM; 4:00 AM - 8:00 AM) for S	0 AM - 8:00 AM), Monday three designated shifts (8:00 PM - 12:00 AM; and 12:00 aturday and Sunday. The ed that some staff only	W 44	The facility's manageme conduct fire drills quarter shift for week days and value will monitor for cor quarterly.	rly for each weekends.	3/31/19
	February 13, 2019, I revealed that there we that drills were held AM weekend shifts f September 2018 and weekend shifts from December 2018. The reports on February confirmed that there	r's fire drill records on beginning at 3:18 PM, was no documented evidence during the 4:00 PM - 12:00 from April 2018 through d the 12:00 AM - 8:00 AM, April 2018 through e QIDP reviewed the fire drill 15, 2019, at 9:30 AM and was no evidence that drills ng the aforementioned time				
	provide evidence that least quarterly for each MEAL SERVICES CFR(s): 483.480(b)(2) Food must be served This STANDARD is r		W 472	The facility nutritionist will training for staff on currer for Client #2 to help prom weight loss. QIDP/ Nutrit for implementation. Staff will receive additional client #2 nutritional assesses	nt diet order note her tionist will m al training o	onitor
	review, the facility fail- were served in the pro three clients in the sa	ed to ensure that snacks escribed quantity, for one of		that snacks are served in quantity.	the prescril	3/21/19
	Findings included:				Ð	
(On 02/13/19 at 8:45 A	M, Client #2 was observed			1	

		E & WEDICAID SERVICES		0	MB NO. 0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G062	B. WING_		02/15/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/10/2019
	NITY MULTI SERVICE			WASHINGTON, DC 20011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 472	seated in the living be overweight. At 3 home from her day #2 washed her han snack, where a vari Continued observat Jello and a mixed fr Client #2 finished be spoon and the contact. On 02/14/19 beginn	ge 6 reom. Client #2 appeared to :23 PM, Client #2 arrived program. At 3:38 PM, Client ds and sat at the table for ety of snacks were placed. ion revealed Client #2 chose uit cup for her snack. After oth snacks, she took her ainers to the kitchen. ing at 9:40 AM, review of al Assessment dated	W 47:	2	1
	08/16/18, revealed to promote weight loss portion control, one weight range was 11 Client #2's weight chally 2018, 210 lbs. in February 2018	he following diet order to : "1500 calorie diet, follow snack per day" and her BMI 0-140 lbs. According to lart, she weighed 207 lbs. in 1 December 2018 and 216			V)
(On 02/15/19 at 3:45 Client #2 was suppo: snack item during he	PM, DSP #3 stated that sed to only receive one or evening snack.			3×2
6	ensure that all staff in	vey, the facility failed to applemented Client #2's promote weight loss.			
					*
					:

If continuation sheet 1 of 6

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: HFD03-0083 B. WING 02/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE PREFIX . (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1000 INITIAL COMMENTS 1000 A licensure survey was conducted from 02/13/19 through 02/15/19. Three residents were selected from a population of six women with intellectual disabilities. A fourth person, Resident #6, was added for a focused review of the Resident's staffing and behavior support needs. This survey was conducted using the focused fundamental survey process. 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. BSP - Behavior Support Plan DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities IPP - Individual Program Plan LPN - Licensed Practical Nurse POS - Physician's Orders Sheets QIDP - Qualified Intellectual Disabilities Professional °F - Degree Fahrenheit 1135 3505.5 FIRE SAFETY 1135 Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift, This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to hold evacuation drills quarterly, for two of the six shifts of duty reviewed (weekend 4:00 PM - 12:00 AM and 12:00 AM - 8:00 AM). Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation & Licensin	ng Administration			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
Marie Carlos Santa	HFD03-0083	B. WING		02/15/2019
NAME OF PROVIDER OR SUPPLIER	STREETA	DDRESS, CIT	Y, STATE, ZIP CODE	1 02/13/2019
COMMUNITY MULTI SERVICE	S. INC	GTON, DC		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
1 135 Continued From page	je 1	1 135		
Findings included:				A A
the QIDP revealed the designated shifts (8: 12:00 AM; and 12:00 through Friday and the AM - 4:00 PM; 4:00 AM - 8:00 AM) for Sa	00 AM - 4:00 PM; 4:00 PM - 0 AM - 8:00 AM), Monday nree designated shifts (8:00 PM - 12:00 AM; and 12:00 aturday and Sunday. The ad that some staff only	The state of the s	The facility's management s conduct fire drills quarterly f shift for weekends and week QIDP will review records for quarterly.	or each i kdavs.
that drills were held d AM weekend shifts for September 2018 and weekend shifts from A December 2018. The reports on February 1 confirmed that there y	eginning at 3:18 PM, as no documented evidence uring the 4:00 PM - 12:00 om April 2018 through the 12:00 AM - 8:00 AM		9:	
At the time of the surv provide evidence that least quarterly for each	fire drills were conducted at			i
1 422 3521.3 HABILITATION	AND TRAINING	1 422	The never old gift will provide	lue in her
Each GHMRP shall pro and assistance to resident 's Individu	ovide habilitation, training dents in accordance with all Habilitation Plan.		The psychologist will provide to be Client #6 BSP to all one/or documentation and one/one p QIDP/Psychologist will monito compliance.	e staff on rotocol
This Statute is not me Based on observation, review, the GHIID failed	interview and record			5/21/18

(X4) ID PREFIX TAG	ROVIDER OR SUPPLIER ITY MULTI SERVICE: SUMMARY STAT	S. INC	B WING	TATE ZIP CODE	02/15	/2019
(X4) ID PREFIX TAG	ITY MULTI SERVICE:	S. INC	ODRESS, CITY, S	TATE ZIP CODE		110010
(X4) ID PREFIX TAG	SUMMARY STAT	S. INC				
PRÉFIX TAG		LAPA OF TILE	200 DO 40			
PRÉFIX TAG			GTON, DC 20			
		MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
	Continued From pag	je 2	1422			<u> </u>
	supervision (one-to- BSP, for one of three	e recommended staff one) in accordance with the e residents of the facility with staffing supports (Resident			i	
. •	manigs moladed.		r l		3.5	
, (On 02/13/19 from 7:3	30 AM to 9:06 AM and from			8	
5 F a re w	emained within arm' :16 PM, the staff wh Resident #6's one-to- nother staff (DSP #2 esidents. At the time rere in the living roor 5 was seated (out o	observations showed staff s length of Resident #6. At to had identified herself as one staff (DSP #1) told 2) that she would "watch" the , Residents #1, 2 and 6 m with DSP #1 and Resident f view) in the dining room.				
R W R W Re re	t 5:17 PM, Resident alking into a side room. She was obser alking towards a bar esident #5 reached ere down around he as exposed. At 5:18 esident #5 in the bar mained in the living	the bathroom, her pants r ankles and her buttocks PM, DSP #1 went to assist throom while Resident #6 room without staff				
ba rod livi we as livi	om while DSP #1 re ing room. Almost im ent back into the bat sist her. At the time, ing room without sta	5 took a seat in the side joined Resident #6 in the mediately, Resident #5 hroom and DSP #1 went to Resident #6 was in the ff supervision again. After pm, DSP #1 and Resident			X	

Health Regulation & Licensi	ng Administration			FORM APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		M. DOIEDING.		
	HFD03-0083	B. WING		02/15/2019
IAME OF PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE	
COMMUNITY MULTI SERVICE	S, INC	IGTON, DC 200°	14	
PREFIX (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
1 422 Continued From pa	ge 3	1422		
On 02/13/19 at 5:20 #6 received one-to-Residents #1 and 5 confirmed that she would watch the off was "medication timescorted residents to the stated that the resident remain within arm's times. On 02/14/19 at 10:44 screaming and wrist targeted behaviors in one-to-ones should Immediate review of 12/05/18, confirmed that between 6:00 Afto remain "within arm On 02/14/19 at 12:07 in-service training reconsulting psycholog Resident #6's BSP of both DSPs #1 and 2 attendance. In addition documented training protocol on 08/08/18, signed the attendance and 2.	D PM, DSP #1 said Resident one supervision whereas did not. DSP #1 then had told DSP #2 that she her residents, explaining that it her and DSP #2 routinely upstairs in a specific order. AM, when asked about co-one coverage, DSP #1 ent's BSP required staff to reach of the resident at all the biting were among the name Resident #6's #6's BSP and remain within arm's length. Resident #6's BSP, dated this. The BSP also stated M and 10:00 PM, staff were he's reach" at all times. PM, review of staff cords showed that the ist had trained staff on an 12/12/18. Signatures of indicated that they were in on, the QIDP had staff on the one-to-one Four one-to-one staff had a sheet, including DSPs #1			2005 54
At the time of the sun ensure that Resident implemented the BSP	/ey, the facility failed to #6's one-to-one staff , as recommended.			÷
i i	i i	1		Ÿ

Health	Regulation & Licensi	ing Administration			FORM APPROVE
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
		HFD03-0083	B. WING		02/15/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CIT	Y, STAYE, ZIP CODE	1 02/15/2019
COMMU	NITY MULTI SERVICE	ES, INC WASHING	STON, DC	20011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
1 500	Continued From pa	nge 4	1 500		
I 500 ⁶	3523.1 RESIDENT	'S RIGHTS	1 500	Water temperature will be m	onitored
	that the rights of res protected in accord	dence director shall ensure sidents are observed and ance with D.C. Law 2-137, this applicable District and federal		and recorded daily to ensure temperature does not excee degrees fahrenheit. QIDP/M Team will monitor for compli	d 110 aintenance
The second secon	This Statute is not a Based on observation review, the GHIID faceach resident's right Chapter 13 of the D. Law 2-137, D.C. Confederal regulations 4 Intermediate Care F	met as evidenced by: ons, interviews and record ailed to observe and protect ts in accordance with Title 7, .C. Code (formerly called D.C. de, Title 6, Chapter 19) and 12 CFR 483 Sub-Part 1 (for acilities for Individuals with es), for three of six residents ents #3, 4 and 6).		Staff received additional train strategies to protect clients' resocial worker provided training Bill of Rights for Residents # #4, #5 and #6.	ights. The
F	Findings included:				-16
∜t	483.470(d)(3)] The he water temperatur ollows:	GHIID failed to ensure that re did not exceed 110°F, as			
b n	at 12:22 PM, water from the standard of the standard of the water letermined to be 114	temperature was °F. Continued inspection of			.i. .i.
, b	ne first floor and sec athrooms also revea 10°F as evidenced b	aled hot water that exceeded			# ·
Fi	itchen faucet - 114°l irst floor bathroom - econd floor bathroor	114°F			The second
0	n 02/15/19 the QIDF	was interviewed at 12:25			j.

STATEMENT OF	nesiciendie	ng Administration			FORM APPR
AND PLAN OF C	ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IG:	(X3) DATE SURVE COMPLETED
		HFD03-0083	B. WING_		02/15/201
NAME OF PROVI	DER OR SUPPLIER	STREETA	DDRESS, CITY	/, STATE, ZIP CODE	
COMMUNITY	MULTI SERVICE	ES. INC			
(X4) ID		WASHIN TEMENT OF DEFICIENCIES	GTON, DC		
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COME E APPROPRIATE DA
I 500 Con	tinued From pa	ge 5	1 500		
QID exce Acco (Res cogr	eded the requined and the color of the color	hot water temperatures. The d that the water was hot and red temperature of 110°F. DP, three of six residents and 5) have adaptive and s to control water		The facility's water tempose checked daily and reensure that the water tenot exceed 110 degrees QIDP/Maintenance Teafor compliance.	ecorded to imperature does s fahrenheit.
temp the n temp indica turne On 00 surve the h	erature on 02/1 naintenance emeratures. The rated that the wad down to achie 2/15/19, at approper and the ma	tification of the hot water 15/19, the QIDP reported to oployee to check the water maintenance employee after temperature would be eve the 110°F for safety. Toximately 4:00 PM, the intenance employee checked ratures again, which revealed	the same section of the sa		
Kitche First I	en faucet - 110° loor bathroom ad Floor bathro	- 109°F			9 5 0 = 8
					î.
that th	e water tempe	, the facility failed to ensure rature did not exceed 110°F.			î
		i			X 0
					6
*		4			
ŕ					
1		1			1
lit.					1
Q.					
Ī	censing Administra		- 1		

		AND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/08/201 MAPPROVE
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
		09G062	8, WING		0.	2/15/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	21 13120 13
COMMI	UNITY MULTI SERVICE	ES, INC		WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE AGTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
	An emergency prep conducted from 02/	paredness survey was 13/19 through 02/15/19.				
	The findings of the	survey were based on		¥		ļ
	interviews and revie preparedness progr	w of the emergency				i i
	Note: The below are appear throughout to	e abbreviations that may he body of this report.				
	CP - Communication			w.		î
	EP - Emergency Pla	n reparedness Program		18		
	PEP - Personal Eme	ergency Plan				
	QIDP - Qualified Inte Professional	ellectual Disabilities				Ü
	RA - Risk Assessme	nt				i i
	TME - Trained Medic % - Percent			d .		*) - ()
E 006	Plan Based on All Ha CFR(s): 483.475(a)(azards Risk Assessment 1)-(2)	E 00	The CMS Program Directo	r has	a.
	and maintain an eme	The [facility] must develop ergency preparedness plan d, and updated at least ust do the following:]		developed a policy for Mas and Civil Disturbance for the The facility's staff will recei on the policies and procedu	ne facility. ve training	i
	facility-based and cor	Include a documented, ⊓munity-based risk an all-hazards approach.*				1
10	on and include a docu community-based rist	§483.73(a)(1):] (1) Be based umented, facility-based and cassessment, utilizing an including missing residents.				
		3.475(a)(1):] (1) Be based on			, u	6.
RATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TUPES	Wi).E		(X6) DATE C

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.

CENTERS FOR MEDIC	CARE & MEDICAID SERVICES				APPROVEI 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	09G062	B. WING		02/	15/2019
NAME OF PROVIDER OR SUP	PLIER	STR	EET ADDRESS, CITY, STATE, ZIF CO	DDE	10/2013
COMMUNITY MULTI SER	RVICES, INC	WA	SHINGTON, DC 20011		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES DENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S GROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
community-bas	documented, facility-based and sed risk assessment, utilizing an	E 006			
	proach, including missing clients.				
(2) Include stra events identifie	ategies for addressing emergency d by the risk assessment.				
strategies for a identified by the management o failures, natural that would affectare. This STANDAR Based on inter	s at §418.113(a)(2):] (2) Include ddressing emergency events a risk assessment, including the fithe consequences of power disasters, and other emergencies at the hospice's ability to provide D is not met as evidenced by:	E .		į	
failed to establis each hazard ide	sh emergency plans to address entified in the RA, for six of six in the facility (Clients #1, 2, 3, 4, 5	5) 6)			
Findings include	d;				
beginning at 10: facility's RA had	iew with the QIDP on 02/15/19 30 AM, the QIDP stated that the identified snow and ice storms derstorms as the greatest s.		· ·		
facility's EPP dat RA (not dated) si Disturbance were overall risk, resp Thunderstorm" w "Blizzard" were b was 22%. Contin plan on how to ac	ginning at 1:20 PM, review of the ed 12/11/18, revealed that the howed Mass Casualty and Civil e identified at 44% and 41% ectively. The risk of "Severe ras 33%, "Snowfall" and oth at 28%, and "Heat/Humidity" ued review showed there was no ddress Mass Casualty and Civil QIDP acknowledged the RA			i i	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	09G062	B. WING	02/15/2019
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICE:	s, INC	STREET ADDRESS, CITY, STATE, ZIP COD WASHINGTON, DC 20011	7 02/13/2019 DE
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
and Civil Disturbance "still developing police address" those risks At the time of the surdeveloped a plan to a assessed as being the This is a repeat defice Deficiency Report date E 007 EP Program Patient I CFR(s): 483.475(a)(3) [(a) Emergency Plantian and maintain an emerith that must be reviewed annually. The plan must be the facility] I han emergency; and continuitied to, person the facility of the including delegations plans.** *Note: ["Persons at rist hospice, PACE, HHA, FQHC, or ESRD facility This STANDARD is not be seen to add the emergency plan to add the determined to be the not account of the surface of the su	rall risk for Mass Casualty e, then stated the facility was cies and procedures to continuity of operations, of authority and succession cies. ciency. See Federal cient objoint and updated at least cust do the following: cient population, including, cons at-risk; the type of continuity of operations, of authority and succession cik' does not apply to: ASC, CORF, CMCH, RHC, cies. cies. cient as evidenced by: cient are cord review, the facility cies and procedures in the circs the clients continuity of operations in the circs the clients continuity of continuity of continuity cies and procedures in the circs the clients continuity of continuity cies and procedures in the circs the clients continuity of continuity cies and procedures in the circs the clients continuity of continuity cies and procedures in the circs the clients continuity of continuity cies and procedures in the cies the clients continuity of continuity cies and procedures in the cies the clients continuity of continuity cies and procedures in the cies the clients continuity of continuity cies and procedures in the cies the clients continuity of continuity cies and procedures in the cies the clients continuity of continuity cies and cies and continuity cies and c	E 007 The QIDP will revise the PE Client #3 and #6 to include personal/behavioral needs to follow in the event of an evacuation.	specific for staff

PRINTED: 03/08/2019 FORM APPROVED

CENTERS FOR MEDICAR	RE & MEDICAID SERVICES			MB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G062	8 WING	WW.	02/15/2019
NAME OF PROVIDER OR SUPPLIE	R	S	TREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2015
COMMUNITY MULTI SERVICE	CES, INC	V	ASHINGTON, DC 20011	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION
E 007 Continued From p	age 3	E 007		
12/11/18) at 1:40 I 12/11/18) at 1:52 I identified the need supports from 6:00 PEP, however, she address the clients the event of an em Both clients had be one-to-one staff du the survey. The clients staffing was not re in the facility's over				en e
about the one-to-or Clients #3 and 6 re supports during wa needs. When the C staffing needs had evacuations, include	5 PM, the QIDP was asked no staffing. She stated that ceived one-to-one staffing king hours due to behavioral QIDP was asked if the clients' been assessed for emergencying the overnight hours, she the clients would benefit			75 10 25
from having one-to- evacuation. The QI the client's emerger aforementioned bel	one staffing during an DP then acknowledged that ncy plans failed to reflect the navioral risks and staffing and 6 during an emergency			Ř
ensure that the EPF aforementioned risk	urvey, the facility failed to P and/or PEP included the to ensure client's health and ter an emergency evacuation.	E 033		2)
CFR(s): 483.475(c)		_ 000		

[(c) The [facility] must develop and maintain an

PRINTED: 03/08/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING COMPLETED 09G062 B. WING 02/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC. WASHINGTON, DC 20011

E 033 Continued From page 4

(X4) ID PREFIX

TAG

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:

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

- (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.
- (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]
- (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

"[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies that addressed E 033

ID PREFIX

TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

(X5) COMPLETION DATE

CENT	ERS FOR WEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G062	B. WING _		02/15/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
COMMU	INITY MULTI SERVICE	S, INC		WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
E 033	client-specific medic health care provider	ty would use to share cal information with other is to maintain the continuity of ients residing in the facility	E 030	}	11	
	On 02/15/19 at 11:14 each client's persons would be put in their the facility had estab procedures that outlifacility would share conformation with other began reviewing the approximately seven was unable to find a protection of clients' during an evacuation progressed, however	minutes, she stated that she policy that outlines the confidential information. As the discussion the QIDP stated at 11:40 found a Communication				
	"Policy/Procedures for Pharmaceutical Support (not dated) revealed to "On-site designated start to pack a and place in the to go or designated staff with security of the medical all times The TME or responsible for maintain neurances, passports person (sic) information imes." The policy did	PM, review of the facility's or Medications and other blies during an Emergency" the following: staff will be instructed by all medications and supplies or roller suitcaseThe TME be responsible for the attornand medical supplies at resignated staff will be an aining all relevant medical and other health-related on in their possession at all not, however, outline how tial information would be	9			

CENTE		& MEDICAID SERVICES				OM	FORM APPROVE B NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	Control Control	X3) DATE SURVEY COMPLETED
VIII.		09G062	B WING				02/15/2019
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	02/15/2019
COMMU	NITY MULTI SERVICE	S, INC		WAS	SHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Ī	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
	emergency evacuat Fire and Natural Dis revealed that a supp placed in "safety loc review of the CP, da had identified during revealed that it dealt for sharing EP-relate their familles and gur provide written instruction confidential information other health provider	ealth providers during an ion. At 2:34 PM, review of a aster Plan, dated 08/27/18, bly of medication would be ked boxes." At 2:57 PM, ted 08/27/18, which the QIDP an earlier conversation solely with the procedures and information with clients and ardians. The CP did not octions regarding how on would be shared with s during emergencies.	E 03	oth me me pro	e Program Director will licy/ Procedure for Med her Pharmaceutical Sup ethods for sharing inforr edical documentation w oviders.	pplies to mation ith othe	and include and
\ \ \ F "	02/15/18 at 3:47 PM, "to go bags" were the suitcase." The QIDP facility; some had roll packs. When asked a stated that those were bags" and were to be medications. When a operational, she state were not yet impleme When this topic was o conference on 02/15/ PM, the facility's prog- Policy/Procedures fo	sked if lock boxes were d that no, the lock boxes nted for the clients. discussed during the exit 19 at approximately 5:00 ram director stated that the Medications and other lies during an Emergency"		tran	k boxes will be purchas isporting medications a suments during an evac	nd othe	ar 3/31/19
th s a	nat the facility's CP ac haring information an s necessary, with oth	ey, there was no evidence ddressed the method for d medical documentation, er health providers to care during an emergency.					7.5 7.5 1.5 1.5 1.5 1.5 1.5 1.5 1.5 1.5 1.5 1

PRINTED: 03/08/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G062 B. WING 02/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC. WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 033 Continued From page 7 E 033 This is a repeat deficiency. See Federal Deficiency Report dated 05/03/18. E 034 Information on Occupancy/Needs E 034 CFR(s): 483.475(c)(7) [(c) The [facility] 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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's

designee.

inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility
failed to develop written policies that addressed
the means by which it would provide information
about the facility's occupancy, needs, and its
ability to provide assistance to the authority
having jurisdiction, for six of six clients residing in

the facility (Clients #1, 2, 3, 4, 5 and 6).

		E & MEDICAID SERVICES				ORM APPROVEI NO. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	TIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
	22117	09G062	B. WING _			02/15/2019
NAME OF	PROVIDER OR SUPPLIER	A	1	STREET ADDRESS, CITY, STATE, ZIP		02/13/2013
COMMU	INITY MULTI SERVICE	ES, INC	150	WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
E 034	Continued From pa	ge 8	E 03	34		
	Findings included:					
	the facility had esta procedures that out facility would provid facility's occupancy, provide assistance jurisdiction. She rep that outlined the proprogram director or would handle commofficials. On 02/15/19 at 2:57 08/27/18, revealed reguldance regarding with the authority has	15 AM, the QIDP was asked if blished written policies and lined the means by which the e information about the needs, and its ability to to the authority having lied there was no EP policy cess; however, either the assistant program director funications with outside. PM, review of the CP, dated to written instructions or how the facility would share ving jurisdiction the facility's or its ability to provide.	3	The facility's Communic will be revised to include for conveying to the aut facility's needs and abili assistance during an en	e procedur horities the ty to provid	res e de
	assistance during an When this topic was conference on 02/15 PM, the facility's prog senior administrators ocal and federal emo	discussed during the exit //19 at approximately 5:05 gram director confirmed that would communicate with argency officials.				
t f l	hat the facility's CP a acility would use to c naving jurisdiction its	vey, there was no evidence addressed the method the convey to the authority occupancy, its needs, ovide assistance during an				10 10 10 10 10 10 10 10 10 10 10 10 10 1
	his is a repeat defici Deficiency Report dat					l i