PRINTED: 03/08/2019
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
	09G062	A. BUILDING ______ B. WING ______	02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	[redacted] 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 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 000		
W 252	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:	W 252		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cantance A. Reese | TITLE: Program Director | (X6) DATE: 3/20/19

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 252	Continued From page 1 Based on observation, interview and record review, the facility failed to ensure that each maladaptive behavior was documented in accordance with each client's BSP, for one of six clients residing in the facility (Client #6). Findings included: On 02/13/18 at 5:31 PM, evening observations showed the following: - At 5:32 PM, Client #6 began shrieking loudly and biting her wrist while seated in a chair in the living room. DSP #1 offered her a variety of activities such as walking or changing stations on the radio. At 5:36 PM, the client calmed after she began playing with Legos (a favored activity) on a mat on the floor. - At 5:46 PM, Client #6, who was seated again in the chair, began shrieking and biting her wrist. DSP #1 offered her a variety of activities such as listening to the radio or playing with the Legos again. The client was observed to calm down more quickly this time. - At 5:49 PM, Client #6 began shrieking again and leaned forward in the chair. DSP #1 immediately assisted the client to the floor. Client #6 picked up a Lego piece, calmly handed it to DSP #1 and then got back into the chair. - At 5:51 PM, the QIDP spoke with Client #6 and asked that the LPN who had been administering medications upstairs come assess the client for pain. Moments later, the LPN came to assess the client. - At 5:56 PM, Client #6 shrieked and bit her wrist.	W 252	Staff will receive additional training on how to properly document Client #6 maladaptive behavior on client's behavior data sheets on every shift by psychologist. During observation of behavior, management will remind staff to document. QIDP/ Res. Mgr/ QA & Night Supervisor will monitor for compliance.	3/21/19

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W 252	Continued From page 2 When the client began flicking her wrist in a dismissive way towards the LPN and DSP #1, the LPN walked away. DSP #1 turned on the radio and asked the client to select a station. The client calmed down. On 02/14/19 at 10:00 AM, review of Client #6's behavior data sheets showed no evidence that the behaviors observed on the previous evening between 5:32 PM and 5:56 PM had been documented. On 02/14/19 at 10:40 AM, the QIDP stated that screaming and wrist biting were among the targeted behaviors in Client #6's BSP and should have been documented in the record. She further stated that she would speak with DSP #1, who was upstairs in the facility at the time. The QIDP returned at 10:46 AM, stating that DSP #1 had acknowledged to her that she had failed to document the behaviors on the day before and that she would make late entries on the client's behavior data sheets. Immediate review of Client #6's BSP, dated 12/05/18, confirmed that screaming and wrist biting were among the targeted behaviors and that staff should document all target behaviors. On 02/14/19 at 12:07 PM, review of staff in-service training records showed that the consulting psychologist had trained staff on Client #6's BSP on 12/12/18. The corresponding signature sheet documented that DSP #1 had been in attendance. At the time of the survey, the facility failed to ensure that Client #6's targeted behaviors of screaming and wrist biting were documented in	W 252	The facility's psychologist will provide training to DSP#1 and staff on the importance of documenting Client #6 target behaviors.	3/21/19

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W 252	Continued From page 3 accordance with the BSP.	W 252		
W 426	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 observation and interview, the facility failed to ensure that the water temperature did not exceed 110°F, for six of six clients residing in the facility (Client #1, 2, 3, 4, 5 and 6). Findings included: During the environmental inspection on 02/15/19, at 12:22 PM, water from the faucet of the bathroom sink was hot to touch. When measured, the water temperature was determined to be 114°F. Continued inspection of the first floor and second floor sinks and bathrooms also revealed hot water that exceeded 110°F as evidenced by the following: Kitchen faucet - 114°F First floor bathroom - 114°F Second floor bathroom - 114°F On 02/15/19 the QIDP was interviewed at 12:25 PM, concerning the hot water temperatures. The QIDP acknowledged that the water was hot and exceeded the required temperature of 110°F. According to the QIDP, three of six clients (Client #1, 2, and 5) have adaptive and cognitive	W 426	Water temperature will be monitored and recorded daily to ensure that water temperature does not exceed 110 degrees fahrenheit.	2/15/19

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W 426	Continued From page 4 capabilities to control water temperatures. 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 turned down to achieve the 110°F for safety. On 02/15/19, at approximately 4:00 PM, the surveyor and the maintenance employee checked the hot water temperatures again, which revealed the following: Kitchen faucet - 110°F First floor bathroom - 109°F Second Floor bathroom- 110°F At the time of survey, the facility failed to ensure that the water temperature did not exceed 110°F.	W 426	The facility's water temperature will be checked daily and recorded to ensure that the water temperature does not exceed 110 degrees fahrenheit. QIDP/Maintenance Team will monitor for compliance.	3/15/19
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility 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). Findings included: On February 13, 2019, at 3:16 PM, interview with the QIDP revealed that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM -	W 440		

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W 440	Continued From page 5 12:00 AM; and 12:00 AM - 8:00 AM), Monday through Friday and three designated shifts (8:00 AM - 4:00 PM; 4:00 PM - 12:00 AM; and 12:00 AM - 8:00 AM) for Saturday and Sunday. The QIDP further indicated that some staff only worked on weekends. Review of the facility's fire drill records on February 13, 2019, beginning at 3:18 PM, revealed that there was no documented evidence that drills were held during the 4:00 PM - 12:00 AM weekend shifts from April 2018 through September 2018 and the 12:00 AM - 8:00 AM, weekend shifts from April 2018 through December 2018. The QIDP reviewed the fire drill reports on February 15, 2019, at 9:30 AM and confirmed that there was no evidence that drills were conducted during the aforementioned time periods. At the time of the survey, the facility failed to provide evidence that fire drills were conducted at least quarterly for each shift of personnel.	W 440	The facility's management staff will conduct fire drills quarterly for each shift for week days and weekends. QIDP will monitor for completion quarterly.	3/31/19
W 472	MEAL SERVICES CFR(s): 483.480(b)(2)(i) Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that snacks were served in the prescribed quantity, for one of three clients in the sample (Client #2). Findings included: On 02/13/19 at 8:45 AM, Client #2 was observed	W 472	The facility nutritionist will provide training for staff on current diet orders for Client #2 to help promote her weight loss. QIDP/ Nutritionist will monitor for implementation. Staff will receive additional training on Client #2 nutritional assessment to ensure that snacks are served in the prescribed quantity.	3/21/19

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W 472	Continued From page 6	W 472		

seated in the living room. Client #2 appeared to be overweight. At 3:23 PM, Client #2 arrived home from her day program. At 3:38 PM, Client #2 washed her hands and sat at the table for snack, where a variety of snacks were placed. Continued observation revealed Client #2 chose Jello and a mixed fruit cup for her snack. After Client #2 finished both snacks, she took her spoon and the containers to the kitchen.

On 02/14/19 beginning at 9:40 AM, review of Client #2's Nutritional Assessment dated 08/16/18, revealed the following diet order to promote weight loss: "1500 calorie diet, follow portion control, one snack per day" and her BMI weight range was 110-140 lbs. According to Client #2's weight chart, she weighed 207 lbs. in July 2018, 210 lbs. in December 2018 and 216 lbs. in February 2019.

On 02/15/19 at 3:45 PM, DSP #3 stated that Client #2 was supposed to only receive one snack item during her evening snack.

At the time of the survey, the facility failed to ensure that all staff implemented Client #2's current diet orders to promote weight loss.

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS 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	I 000		
I 135	3505.5 FIRE SAFETY 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).	I 135		

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Contrasse A. Reece — TITLE: Program Director — (X6) DATE: 3/20/19

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I 135	Continued From page 1 Findings included: On February 13, 2019, at 3:16 PM, interview with the QIDP revealed that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM - 12:00 AM; and 12:00 AM - 8:00 AM), Monday through Friday and three designated shifts (8:00 AM - 4:00 PM; 4:00 PM - 12:00 AM; and 12:00 AM - 8:00 AM) for Saturday and Sunday. The QIDP further indicated that some staff only worked on weekends. Review of the facility's fire drill records on February 13, 2019, beginning at 3:18 PM, revealed that there was no documented evidence that drills were held during the 4:00 PM - 12:00 AM weekend shifts from April 2018 through September 2018 and the 12:00 AM - 8:00 AM, weekend shifts from April 2018 through December 2018. The QIDP reviewed the fire drill reports on February 15, 2019, at 9:30 AM and confirmed that there was no evidence that drills were conducted during the aforementioned time periods. At the time of the survey, the facility failed to provide evidence that fire drills were conducted at least quarterly for each shift of personnel.	I 135	The facility's management staff will conduct fire drills quarterly for each shift for weekends and weekdays. QIDP will review records for completion quarterly.	3/31/19
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that each	I 422	The psychologist will provide training on Client #6 BSP to all one/one staff on documentation and one/one protocol. QIDP/Psychologist will monitor for compliance.	3/21/19

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I 422	Continued From page 2 resident received the recommended staff supervision (one-to-one) in accordance with the BSP, for one of three residents of the facility with assigned one-to-one staffing supports (Resident #6). Findings included: On 02/13/19 from 7:30 AM to 9:06 AM and from 3:23 PM to 5:16 PM, observations showed staff remained within arm's length of Resident #6. At 5:16 PM, the staff who had identified herself as Resident #6's one-to-one staff (DSP #1) told another staff (DSP #2) that she would "watch" the residents. At the time, Residents #1, 2 and 6 were in the living room with DSP #1 and Resident #5 was seated (out of view) in the dining room. DSP #2 promptly escorted Resident #2 upstairs. At 5:17 PM, Resident #5 stood up and began walking into a side room adjacent to the dining room. She was observed lowering her pants while walking towards a bathroom. By the time Resident #5 reached the bathroom, her pants were down around her ankles and her buttocks was exposed. At 5:18 PM, DSP #1 went to assist Resident #5 in the bathroom while Resident #6 remained in the living room without staff supervision. A moment later, they left the bathroom; Resident #5 took a seat in the side room while DSP #1 rejoined Resident #6 in the living room. Almost immediately, Resident #5 went back into the bathroom and DSP #1 went to assist her. At the time, Resident #6 was in the living room without staff supervision again. After finishing in the bathroom, DSP #1 and Resident #5 went to the living room, where Resident #5 took a seat and DSP #1 went to Resident #6's side. [Note: Resident #6 was not initially included in the core sample.]	I 422		

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I 422	Continued From page 3	I 422		

Continued From page 3

On 02/13/19 at 5:20 PM, DSP #1 said Resident #6 received one-to-one supervision whereas Residents #1 and 5 did not. DSP #1 then confirmed that she had told DSP #2 that she would watch the other residents, explaining that it was "medication time" and DSP #2 routinely escorted residents upstairs in a specific order.

On 02/14/19 at 9:22 AM, when asked about Resident #6's one-to-one coverage, DSP #1 stated that the resident's BSP required staff to remain within arm's reach of the resident at all times.

On 02/14/19 at 10:40 AM, the QIDP stated that screaming and wrist biting were among the targeted behaviors in Resident #6's #6's BSP and one-to-ones should remain within arm's length. Immediate review of Resident #6's BSP, dated 12/05/18, confirmed this. The BSP also stated that between 6:00 AM and 10:00 PM, staff were to remain "within arm's reach" at all times.

On 02/14/19 at 12:07 PM, review of staff in-service training records showed that the consulting psychologist had trained staff on Resident #6's BSP on 12/12/18. Signatures of both DSPs #1 and 2 indicated that they were in attendance. In addition, the QIDP had documented training staff on the one-to-one protocol on 08/08/18. Four one-to-one staff had signed the attendance sheet, including DSPs #1 and 2.

At the time of the survey, the facility failed to ensure that Resident #6's one-to-one staff implemented the BSP, as recommended.

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I 500	Continued From page 4	I 500		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHIID failed to observe and protect each resident's rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for three of six residents of the facility (Residents #3, 4 and 6). Findings included: [483.470(d)(3)] The GHIID failed to ensure that the water temperature did not exceed 110°F, as follows: During the environmental inspection on 02/15/19, at 12:22 PM, water from the faucet of the bathroom sink was hot to touch. When measured, the water temperature was determined to be 114°F. Continued inspection of the first floor and second floor sinks and bathrooms also revealed hot water that exceeded 110°F as evidenced by the following: Kitchen faucet - 114°F First floor bathroom - 114°F Second floor bathroom - 114°F On 02/15/19 the QIDP was interviewed at 12:25	I 500	Water temperature will be monitored and recorded daily to ensure that water temperature does not exceed 110 degrees fahrenheit. QIDP/Maintenance Team will monitor for compliance. Staff received additional training on strategies to protect clients' rights. The social worker provided training on client's Bill of Rights for Residents #1, #2, #3, #4, #5 and #6.	2/15/19 3/8/19

Health Regulation & Licensing Administration

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I 500	Continued From page 5 PM, concerning the hot water temperatures. The QIDP acknowledged that the water was hot and exceeded the required temperature of 110°F. According to the QIDP, three of six residents (Residents #1, 2, and 5) have adaptive and cognitive capabilities to control water temperatures. 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 turned down to achieve the 110°F for safety. On 02/15/19, at approximately 4:00 PM, the surveyor and the maintenance employee checked the hot water temperatures again, which revealed the following: Kitchen faucet - 110°F First floor bathroom - 109°F Second Floor bathroom- 110°F At the time of survey, the facility failed to ensure that the water temperature did not exceed 110°F.	I 500	The facility's water temperature will be checked daily and recorded to ensure that the water temperature does not exceed 110 degrees fahrenheit. QIDP/Maintenance Team will monitor for compliance.	2/15/19

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	09G062	A. BUILDING ______ B. WING ______	02/15/2019

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COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20011

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E 000	Initial Comments An emergency preparedness survey was conducted from 02/13/19 through 02/15/19. 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 EP - Emergency Plan EPP - Emergency Preparedness Program PEP - Personal Emergency Plan QIDP - Qualified Intellectual Disabilities Professional RA - Risk Assessment TME - Trained Medication Employee % - Percent	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. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on	E 006	The CMS Program Director has developed a policy for Mass Casuality and Civil Disturbance for the facility. The facility's staff will receive training on the policies and procedures.	3/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese
TITLE: Program Director
(X6) DATE: 3/20/19

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		

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 interview and record review, the facility failed to establish emergency plans to address each hazard identified in the RA, for six of six clients residing in the facility (Clients #1, 2, 3, 4, 5 and 6).

Findings included:

During an interview with the QIDP on 02/15/19 beginning at 10:30 AM, the QIDP stated that the facility's RA had identified snow and ice storms and severe thunderstorms as the greatest potential hazards.

On 02/15/19, beginning at 1:20 PM, review of the facility's EPP dated 12/11/18, revealed that the RA (not dated) showed Mass Casualty and Civil Disturbance were identified at 44% and 41% overall risk, respectively. The risk of "Severe Thunderstorm" was 33%, "Snowfall" and "Blizzard" were both at 28%, and "Heat/Humidity" was 22%. Continued review showed there was no plan on how to address Mass Casualty and Civil Disturbance. The QIDP acknowledged the RA

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E 006	Continued From page 2 reflected a high overall risk for Mass Casualty and Civil Disturbance, then stated the facility was "still developing policies and procedures to address" those risks. At the time of the survey, the facility had not developed a plan to address all hazards that were assessed as being the highest risk. This is a repeat deficiency. See Federal Deficiency Report dated 05/03/18.	E 006		
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(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:] (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.** *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 interview and record review, the facility failed to include policies and procedures in the emergency plan to address the clients determined to be the most vulnerable in the risk assessment, for two of six clients residing in the facility (Clients #3 and 6). Findings included:	E 007	The QIDP will revise the PEEP for Client #3 and #6 to include specific personal/behavioral needs for staff to follow in the event of an emergency evacuation.	3/31/19

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On 02/15/19 review of Client #6's PEP (dated 12/11/18) at 1:40 PM and Client #3's PEP (dated 12/11/18) at 1:52 PM revealed that both PEPs identified the need for one-to-one staffing supports from 6:00 AM until 10:00 PM. Neither PEP, however, showed evidence of a plan to address the clients' overnight staffing needs in the event of an emergency evacuation. Note: Both clients had been observed with assigned one-to-one staff during the two preceding days of the survey. The clients' need for one-to-one staffing was not reflected or described elsewhere in the facility's overall EPP.

On 02/15/19 at 3:25 PM, the QIDP was asked about the one-to-one staffing. She stated that Clients #3 and 6 received one-to-one staffing supports during waking hours due to behavioral needs. When the QIDP was asked if the clients' staffing needs had been assessed for emergency evacuations, including the overnight hours, she replied she believed the clients would benefit from having one-to-one staffing during an evacuation. The QIDP then acknowledged that the client's emergency plans failed to reflect the aforementioned behavioral risks and staffing needs for Clients #3 and 6 during an emergency evacuation.

At the time of the survey, the facility failed to ensure that the EPP and/or PEP included the aforementioned risk to ensure client's health and safety during and after an emergency evacuation.

E 033 Methods for Sharing Information
CFR(s): 483.475(c)(4)-(6) — E 033

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

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E 033 Continued From page 4 E 033

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:

(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

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E 033	Continued From page 5	E 033		

the means the facility would use to share client-specific medical information with other health care providers to maintain the continuity of care, for six of six clients residing in the facility (Clients #1, 2, 3, 4, 5 and 6).

Findings included:

On 02/15/19 at 11:14 AM, the QIDP stated that each client's personal, confidential information would be put in their To Go bags. When asked if the facility had established written policies and procedures that outlined the means by which the facility would share client-specific medical information with other health care providers, she began reviewing the EPP binder. After approximately seven minutes, she stated that she was unable to find a policy that outlines the protection of clients' confidential information during an evacuation. As the discussion progressed, however, the QIDP stated at 11:40 AM that she had just found a Communication Plan, dated 08/27/18.

On 02/15/19 at 2:24 PM, review of the facility's "Policy/Procedures for Medications and other Pharmaceutical Supplies during an Emergency" (not dated) revealed the following:
"On-site designated staff will be instructed by nursing staff to pack all medications and supplies and place in the to go roller suitcase...The TME or designated staff will be responsible for the security of the medication and medical supplies at all times...The TME or designated staff will be responsible for maintaining all relevant medical insurances, passports and other health-related person (sic) information in their possession at all times." The policy did not, however, outline how each client's confidential information would be

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E 033	Continued From page 6 shared with other health providers during an emergency evacuation. At 2:34 PM, review of a Fire and Natural Disaster Plan, dated 08/27/18, revealed that a supply of medication would be placed in "safety locked boxes." At 2:57 PM, review of the CP, dated 08/27/18, which the QIDP had identified during an earlier conversation revealed that it dealt solely with the procedures for sharing EP-related information with clients and their families and guardians. The CP did not provide written instructions regarding how confidential information would be shared with other health providers during emergencies. During a follow-up interview with the QIDP on 02/15/18 at 3:47 PM, she was asked whether the "to go bags" were the same as "to go roller suitcase." The QIDP replied that it varied by facility; some had roller bags, others had back packs. When asked about the "lock boxes," she stated that those were different from the "to go bags" and were to be used for storing medications. When asked if lock boxes were operational, she stated that no, the lock boxes were not yet implemented for the clients. When this topic was discussed during the exit conference on 02/15/19 at approximately 5:00 PM, the facility's program director stated that the "Policy/Procedures for Medications and other Pharmaceutical Supplies during an Emergency" provided the necessary guidance. At the time of the survey, there was no evidence that the facility's CP addressed the method for sharing information and medical documentation, as necessary, with other health providers to maintain continuity of care during an emergency.	E 033	The Program Director will revise the Policy/ Procedure for Medication and other Pharmaceutical Supplies to include methods for sharing information and medical documentation with other health providers. Lock boxes will be purchased for transporting medications and other documents during an evacuation.	3/31/19 3/31/19

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E 033	Continued From page 7 This is a repeat deficiency. See Federal Deficiency Report dated 05/03/18.	E 033		
E 034	Information on Occupancy/Needs 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 inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. 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 034		

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E 034 Continued From page 8 E 034

Findings included:

On 02/15/19 at 11:45 AM, the QIDP was asked if the facility had established written policies and procedures that outlined the means by which the facility would provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. She replied there was no EP policy that outlined the process; however, either the program director or assistant program director would handle communications with outside officials.

On 02/15/19 at 2:57 PM, review of the CP, dated 08/27/18, revealed no written instructions or guidance regarding how the facility would share with the authority having jurisdiction the facility's occupancy, needs, or its ability to provide assistance during an emergency.

When this topic was discussed during the exit conference on 02/15/19 at approximately 5:05 PM, the facility's program director confirmed that senior administrators would communicate with local and federal emergency officials.

At the time of the survey, there was no evidence that the facility's CP addressed the method the facility would use to convey to the authority having jurisdiction its occupancy, its needs, and/or its ability to provide assistance during an emergency.

This is a repeat deficiency. See Federal Deficiency Report dated 05/03/18.

Provider's Plan of Correction:

The facility's Communication Plan will be revised to include procedures for conveying to the authorities the facility's needs and ability to provide assistance during an emergency. 3/31/19