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 _____	05/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted from 05/01/19 to 05/03/19. A sample of two clients was selected from four women. The survey was conducted utilizing the focused fundamental survey process.

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

The following abbreviations will appear throughout the report:

DON - Director of Nursing
EC-enteric coated
gm-gram
IPP - Individualized Program Plan
MAR - Medication Administration Record
mg - Milligram
PCP - Primary Care Physician
POS - Physician's Order Sheets
QA - Quality Assurance
QIDP - Qualified Intellectual Disabilities Professional
RN Registered Nurse
SLP - Speech-Language Pathologist
tab-Tablet

W 111	CLIENT RECORDS CFR(s): 483.410(c)(1)	W 111	

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtanee A. Reese	Program Director	6/20/19

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 111	Continued From page 1	W 111		

Based on observation, interview and record review the facility failed to develop a record keeping system to track repairs for one of three clients in the sample (Client #2).

Findings included:

On 05/01/19, beginning at 8:40 AM, Client #2 was observed eating breakfast and later leaving the facility to attend the day program. In the evening the client was observed coloring a picture and eating dinner. Throughout the observations, the client communicated non-verbally. The client was not observed using any communication devices throughout the morning, day, or evening observations.

On 05/01/19 at 9:10 AM, the QIDP provided a copy of Client #2's IPP dated 8/18/19. The IPP objective indicated that the client will properly use the Go-Talk Communication Device to express her needs and wants 80% of trials, 7 days a week.

During an interview with the facility's QA representative on 05/02/19 at 11:40 AM, the QA representative said the Go-Talk Communication Device needed repairs on 04/26/19 therefore, she dropped the device to the SLP. The QA representative also said that she could not determine the date in which the device malfunctioned, nor the status of the device. The QA representative said that she would follow-up with the main office to get a current status. [It should be noted the device was returned to the client on 5/3/19 at the exit.]

On 05/02/19 at 11:44 AM, review of the facility's adaptive equipment policy(undated) documented

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W 111	Continued From page 2 the facility should document (1) the date the problem was identified (2) the exact nature of the problem (3) the name of the supervisor who was notified and continue documentation until the problem was resolved. At 11:46 AM, review of Client #2's record revealed that the above mentioned notes was not in the client's record. The facility's QA representative confirmed the client's record did not document the status of the repair. At the time of the survey, the facility failed to implement the adaptive equipment repair documentation policy.	W 111	The facility's Adaptive Equipment Policy will be implemented by following the procedures listed in the policy. QIDP/RN will document in the records the date the problem was identified/nature of the problem and follow status until problem is resolved. QA will monitor for compliance.	6/30/19
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's medication regimen was reviewed by a pharmacist at least quarterly, for four of four clients in the facility (Clients #1, 2, 3, and 4). Finding included: On 05/01/19, from 4:43 PM to 5:07 PM, RN #1 administered the clients evening medications including the following: A. Client #2: Miralax Powder (17 gm), Carbamazepine 200 mg tab (2 tabs), 400 mg, Chlorpromazine 200 mg tab, and Atorvastatin 10	W 362		

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W 362	Continued From page 3 mg tab B. Client #3: Naltrexone 50 mg tab and Gabapentin 300 mg cap (4 caps), 1200 mg. C. Client #4: Gabapentin 300 mg cap (8 caps) 2400 mg, Naltrexone 50 mg tab, Divalproex EC 500 mg tab, Divalproex Sodium DR 250 mg tab, Calcium 600 + D400 tab D. Client #1: Thioridazine 50 mg tab, Atorvastatin 20 mg tab On 05/01/19 beginning at 5:26 PM, review of the 05/01/19 POS confirmed that the clients were prescribed the aforementioned medications. She further stated that the clients' tolerance of the medications was monitored by the direct support staff, as well as professional staff, including the pharmacist. On 05/02/19, beginning at 10:40 AM, review of the medical records for Client #1's medication showed the last pharmacy drug regimen review was dated 11/08/18. Similarly, Client #2, 3, and 4's record showed pharmacy drug regimen reviews were also dated 11/08/18. A follow-up interview with RN #1 on 05/02/19 at 3:22 PM confirmed that the pharmacist last reviewed the clients' medication regimens on 11/08/18 (five months prior to the survey). The RN stated that there was currently no pharmacist available to the facility. On 05/03/19/ at 2:03 PM, review of the facility's policy on Pharmacy Services showed a pharmacist shall review the following quarterly:	W 362	The facility's pharmacist will conduct quarterly drug regimen reviews. The facility's QIDP/RN will schedule visits for pharmacist to review each client's records. QA will monitor for compliance.	6/30/19

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W 362	Continued From page 4 A. Drugs and dosages currently administered B. Pertinent lab information, including regular blood testing, if indicated C Behavior reports D. Physician's notes At the time of the survey, the facility failed to ensure that a pharmacist conducted quarterly drug regimen reviews as required.	W 362		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility's nurse failed to ensure all prescribed medications were locked when not being prepared, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 05/01/19, between 4:43 PM and 5:01 PM, the staff escorted the clients one by one (Clients #2, 3, and 4) to the nursing office on the second floor for medications. As each client arrived, RN #1 administered the medications and returned them to the cabinet. At 5:03 PM, RN #1 prepared Client #1's medication and also returned them to the cabinet. At 5:08 PM, RN stated that Client #1 receives medications on the first floor because she has difficulty climbing stairs. RN #1 then went to the	W 382		

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W 382	Continued From page 5 first floor to administer Client #1's medications. A combination lock was left hanging unsecured from the front of the medication cabinet. Additionally, the door to the nursing office was unlocked. When the RN returned to the office approximately five minutes later, QIDP #2 was observed sitting at his desk in the office where the medications were stored. The RN #1 stated that the medication cabinet should have been locked when she left the office. On 05/03/19 at 9:37 AM, the facility's medication policy provided instructions to never leave the medications unlocked when out of view. At the time of the survey, the facility failed to ensure that all medications were stored securely when not being prepared for administration.	W 382	The facility's RN will receive additional training on policy/procedure for medication administration by the DON. The Don will review procedures with all nursing staff. DON and QA will monitor for compliance.	6/19/19

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	HFD03-0085	A. BUILDING: _____ B. WING _____	05/03/2019

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I 000	INITIAL COMMENTS A licensure survey was conducted from 05/01/19 to 05/03/19. A sample of two residents was selected from four women. The findings of the survey were based on observations, interviews and review of administrative records. The following abbreviations will appear throughout the report: DON - Director of Nursing IPP - Individualized Program Plan MAR - Medication Administration Record ms - Milligram PCP - Primary Care Physician POS - Physician's Order Sheets QA - Quality Assurance QIDP - Qualified Intellectual Disabilities Professional RN Registered Nurse SLP - Speech-Language Pathologist	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to maintain the environment for four of four residents in the facility (Residents #1, 2, 3, and 4). Findings included:	I 090		

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I 090	Continued From page 1 On 05/01/19 at 9:36 AM, the QIDP stated there is a plan for the residents to relocate to another facility soon. The program director said she expects the move to take place around 06/01/19. On 05/03/19 at 11:15 AM, the QIDP and the surveyor observed the environment. When walking from the first floor to the basement, the tread on the second step of the stairs moved downward. The QIDP said she would ask the maintenance employee to immediately check the step. She also said that the residents do not go to the basement. [Note: The staff used the washer and dryer in the basement daily.] At 12:39 PM, the maintenance employee was at the facility to make repairs. The QIDP and the surveyor observed the basement second step again at 4:05 PM and it was the same. The QIDP agreed to update the program director and the staff to prevent a potential safety hazard. At the time of the survey, the facility failed to ensure that the basement step was maintained.	I 090	Basement steps were temporarily maintained for safety by CMS' Maintenance Team; however, the persons in this facility will be moving to a new location.	6/25/19

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E 000	Initial Comments An emergency preparedness survey was conducted from 05/01/19 through 05/03/19. 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 DSP- Direct Support Professional EP - Emergency Plan EPP - Emergency Preparedness Program QA - Quality Assurance QIDP - Qualified Intellectual Disabilities Professional	E 000		
E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:	E 037		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance A. Reese	Program Director	6/20/19

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E 037	Continued From page 1 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually.	E 037		

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E 037	Continued From page 2 (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.	E 037		

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E 037	Continued From page 3 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain documentation of annual training on the EPP for nine of 11 support staff (DSPs #1, 2, 3, 5, 6, 7, 8, 10, and 11). Findings included:	E 037	The facility's DSPs will receive training on the EPP by CMS Training Coordinator/ QIDP. Initial and Annual Training will be documented with each DSP demonstrating knowledge of emergency procedures.	6/30/19

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E 037	Continued From page 4 On 05/02/19, at 8:55 AM, a request was made of the facility to have initial EP training, annual EP training, and emergency drill records available for review on 05/03/19. On 05/03/19 at 1:37 PM review of the facility's EPP training records showed that the initial EPP training was dated 02/09/18 and 03/23/18. Severe weather, earthquake, floods, tornadoes, fire drills, biological threats, active shooter were the topics. The agenda also noted a tabletop exercise (Active Shooter) and a one half hour competency test. On 05/03/19 at 2:15 PM, a training form dated 04/30/19, showed that the QA coordinator provided an EPP refresher training to DSPs #4, 7, 9 and QIDP #1. The training also included "What to do if there is an active shooter". There was no evidence that the remaining support staff (DSPs #1, 2, 3, 5, 6, 8, 10, and 11) participated in an annual EPP refresher training. At 2:15 PM, review of the training policy dated 11/24/18 revealed that each staff will receive initial and annual training on the facility's EPP. At the time of the survey, there was no documented evidence that each facility staff received annual training on the facility's EPP.	E 037	The Training Coordinator/ QIDP will provide annual refresher training for DSPs #1, 2, 3, 5, 6, 8, 10 and 11, to include training on Active Shooter. Competency tests will be provided for documentation. QIDP/QA will monitor training records for compliance.	6/30/19