PRINTED: 02/25/2019 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY MPLETED
		09G037	B. WING		02/	08/2019
	PROVIDER OR SUPPLIER NITY MULTI SERVICE	S, INC		REET ADDRESS, CITY, STATE, ZIP CODE ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	rs .	W 000			
	02/06/19 through 02 selected from a pop intellectual disabilities was added for a foc nutritional needs. The	vey was conducted from 2/08/19. Three clients were rulation of six men with es. A fourth person, Client #5, used review of the client's survey was conducted andamental survey process.				
À	The findings of the sobservations, intervial administrative record	survey were based on ews and review of client and ds.	ì		Ì	
4	Note: The below are appear throughout the	abbreviations that may ne body of this report.	ĥ			
	% - Percent DSP - Direct Suppor IPP - Individual Prog MAR - Medication Ad MG - Milligram POS - Physician's Or QIDP - Qualified Inte Professional RN - Registered Nurs IME - Trained Medic	ram Plan dministration Record rders Sheets llectual Disabilities se ation Employee	W 189			
in e	CFR(s): 483.430(e)(1) The facility must provinitial and continuing employee to perform efficiently, and competities STANDARD is re-	vide each employee with training that enables the his or her duties effectively, etently.	AA 108			
ir	Based on observation nterview, the facility f	n, record review and staff ailed to ensure that each		TITLE) J		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y9WJ11

Facility ID: 09G037

If continuation sheet Page 1 of 8

CENT	ERS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO	0. 0938-0391
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		09G037	B. WING		0.5	2/08/2019
NAME C	F PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		10012013
COMM	UNITY MULTI SERVICE	ES, INC		WASHINGTON, DC 20008		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 18	9 Continued From pa	ine 1	\\/ 1D/			
		otocol was implemented	W 189	9		
5.	consistently for one (Client #2).	of three clients in the sample		QIDP has provided training for DSP# 16 on Client #2 feeding	g	
	Findings included:			protocol and will document the date/time when the ensure for	r	
	ensure as he sat in Client #2 was serve broccoli and a muffi	5 PM, Client #2 was drinking the living room. At 5:32 PM, d fish, macaroni salad, n. Client #2 refused to eat his ack to the living room at 5:36		Client #2 is given. All DSPs v receive training on Client #2 mealtime protocol and will document the date/time ensu is given to Client #2. QIDP/Nursing Staff will contir to monitor documentation and	re iue	
	mealtime protocol d	7 AM review of Client #2's ated 07/03/18 revealed staff two hours after breakfast and		implementation of feeding pro	otocol.	2/28/19
	in-service training re	6 AM, review of the staff cords showed that all staff Client #2's mealtime protocol				
	#16 confirmed that (on 02/08/19 at 4:15 PM, DSP a Client #2 has a feeding tated that Client #2 receives after his meal.				
W 249	that the training on C had not been effective	ENTATION	W 249			
	As soon as the interc formulated a client's	lisciplinary team has individual program plan, eive a continuous active				

PRINTED: 02/25/2019

		& MEDICAID SERVICES			FORM	M APPROVE
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1			0. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
	0=-23-10-	09G037	B. WING		0.2	2/08/2019
NAME OF	PROVIDER OR SUPPLIER	**************************************	'	STREET ADDRESS, CITY, STATE, ZIF	P CODE	10012019
сомми	NITY MULTI SERVICE	S, INC		WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 249	interventions and se and frequency to su	ge 2 rvices in sufficient number pport the achievement of the in the individual program	W 24	The QIDP will review the goals for both day progresidential for client in himplementation as state person's ISP. QIDP will accurate and proper dofor Client #1.	ram and nome to ensured in each Il monitor for	-
	Based on observation review, the facility standard client's physical fitne was implemented at	not met as evidenced by: on, interview, and record aff failed to ensure each ss and exercise program the recommended three clients in the core		All DSP staff will be re- Client #1 active treatme		3/4/19
	Findings included:					
\ \ \ \ \	Client #1 sitting in the television was on the extended his hand who Client #1 appeared to who stayed home from was observed leaving	AM, observations showed a living room while the news channel. The client nen greeted by the surveyor, be non-verbal. The client, m his day program that day, the facility at 10:35 AM with were going for a walk in the				
t c " a ii F S n	he clients' IPPs. Clie objective (IPP dated 1 [Client's name] will partitivity with a Direct Statemently for 30 retriber review reveals [Support Professionals ame] to use the exer	ninutes 5 days a week." ed the following: "Direct will encourage [client's cise bike/treadmill, do		- ×	3 3 3	
jı T	imping jacks, and/or he client had similar	community walks." [Note: exercise objectives in both s well as his residential		E.		

	CENTERS FOR MEDICARE & MEDICAID SERVICES					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE : COMPI	
		09G037	B. WING		02/0	8/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/00	3/2019
COMMU	NITY MULTI SERVIC	ES, INC	1	WASHINGTON, DC 20008		
(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 APPROPRICIENCY)	O BE ((X5) COMPLETION DATE
W 249	Continued From pa	age 3	W 249		3	
	#11 tapped on Clie were going for a wa turned off his radio, out the front door w	tions showed at 4:15 PM, DSP nt #1's shoulder and said they alk. The client immediately grabbed his coat and went with DSP #11. Client #1 was g the facility with others at 5:05			£	
	performance data s program revealed s following: - 01/2019: ball toss,	M, review of Client #1's heets for his exercise taff had documented the dancing, bike riding, walking			16	
	and,	of exercise on 10 of 31 days; acks or other exercises on 8			8	-
	of 31 days.					
	The data showed Conteria of 20 days p	lient #1 did not meet the er month.			9	
	asked about Client #	AM, the QIDP and RN were this exercise program. The libean recommended by the mealth and weight			ì	
1	management. The C the client would bene	NDP concurred, adding that efit from staying fit because			79 27	
. 7	around the house, In #1's nutrition assess	ed assisting staff with chores nmediate review of Client ment (dated 12/05/18) onist's recommendation for				
t	he exercise progran Client #1 readily part	n. The QIDP stated that icipated in exercise and			6	
9 0 11 11	guessed that perhap fue to cold weather on nonths. When this whe exit conference of	s he had not met the criteria outdoors during the winter as again discussed during on 02/08/19 at approximately	¥ ¥			
5	:UU PM, It was point	ed out that staff had				1

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

		& MEDICAID SERVICES			OMB NO	. 0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	TIPLE CONSTRUCTION NG	(X3) DAT	'E SURVEY IPLETED
	341	09G037	B. WING		02/	08/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/2013
COMMU	NITY MULTI SERVICE	S, INC		WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 4 exercises, such as riding the or dancing to music.	W 24	19		
W 368	At the time of the su ensure that Client#	rvey, the facility failed to 1's exercise objective was recommended frequency. ATION	W 36	8	1	
	The system for drug that all drugs are ad the physician's order	administration must assure ministered in compliance with s.			The state of the s	
	Based on observation review, the facility facilient's medications of the second	POS, for two of six clients			The control of the co	
I	Findings included:				į.	
. 1 T. 0 I V t	nurse's area with his DSP #5. At 8:34 AM, observed to administ ncluding Metocloprativas a certified TME.] the area shortly there	6 AM, Client #6 came to the assigned one-to-one staff, another staff, DSP #8 was er the client's medications, mide 10 mg. [Note: DSP #8 The client and DSP #5 left after. At 8:50 AM, Client #6 breakfast in the dining room, ext to him.		The TME/DSP will be retra on the importance of follow instructions to wait 30 minu- feeding Client #6 after rece metoclopramide. The RN w weekly for compliance.	ving utes prior to eiving	
tl o	current POS and MAI the following: "Metoclo tine tablet by mouth to	AM, review of Client #6's Rs (February 2019) showed opramide 10 mg tablet. Take vice daily - 30 minutes prior er for vomiting "The POS			***************************************	

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CENTE	NO FOR MEDICARE	& MEDICAID SERVICES		**************************************	OMB NO	. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		09G037	B. WING _	The state of the s	02/	08/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 021	UUIZUIS
COMMU	INITY MULTI SERVICE	s, INC		WASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	other medications s On 02/06/19 at 3:30 about Client #6's Me the client should rec meals. When asked discussed the Metoc training, DSP #8 rep 30 minutes." On 02/06/19 at 4:06 about Client #6's Me she (the one-to-one for 30 minutes before confirmed that it had in-service training, as was prescribed to re- further explained tha warm and puree" the acknowledged that s	ge 5 led the Metoclopramide was ministered at 7:30 AM, with cheduled for 8:00 AM. PM, DSP #8 was asked stoclopramide. He stated that eive the medication before if the facility RN had elopramide during in-service lied "they're supposed to wait estaff) was supposed to wait esta	W 36	8		
	2. On 02/06/19 at 8:4 observed administeri 6.5% ear drops in Clidrops in the left ear. I bottle of ear drops bathe ear drops to the sof the label on the bodrops 6.5%. Instill 5 devery month for cerurasked if he was throudrops, DSP #8 replied	ng three drops of Debrox ent #2's right ear and three DSP #8 then placed the ck into its box and handed urveyor. Immediate review x showed the following: "Ear rops in each ear first 7 days nen management." When gh administering the ear I "yes." The surveyor then macy label. After DSP #8		The TME will be retrained by the correct medication admini procedure to include reading physician order sheet, the MA the pharmacy label for consis The RN will monitor TME once for compliance.	stration the R and tency. e a weel	3/8/19

administered two more drops in each ear.

1		E & MEDICAID SERVICES	17		OMB NO	0, 0938-0391
AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	ECONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		09G037	B. WING		0'	2/08/2019
NAME OF	F PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 02	2/00/2019
COMM	UNITY MULTI SERVIC	ES, INC	W	ASHINGTON, DC 20008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 368	B Continued From page	age 6	W 368			
	current POS and N the following: "Ear	57 AM, review of Client #2's IARs (February 2019) showed drops 6.5%. Instill 5 drops in s every month for cerumen				21
	facility's RN usually medications. Shortl of Client #2's MAR were in the boxes u administration of the	D PM, DSP #8 stated that the administered the morning y after he left, however, review revealed DSP #8's initials used to document e ear drops on the mornings 19, 02/04/19, 02/05/19 and		**		
W 369	At the time of the su ensure that Client # Metoclopramide we accordance with the DRUG ADMINISTRA CFR(s): 483.460(k)(POS. ATION	W 369			
	that all drugs, includ	administration must assure ing those that are eadministered without error.				9.
	Based on observation review, the facility far medications were ad	not met as evidenced by: on, interview and record iled to ensure that ail ministered without error, for siding in the facility (Client			JI J	
I	Findings included:		i			
	Cross-refer to W368	I On 02/06/19 at 8:47 AM.	1		3	

PRINTED: 02/25/2019

	FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		09G037	B. WING_		02/08/2019
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
COMMUNIT	Y MULTI SERVICE	S, INC		WASHINGTON, DC 20008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE COMPLETION
On cur the each	Debrox 6.5% ear of three drops in the showed the following in each ear umen management wed him the pharmined the label aninistered two modes and March ear first 7 days nagement."	ed administering three drops drops in Client #2's right ear the left ear. The label on the pwing: "Ear drops 6.5%. Instill first 7 days every month for ent." When the surveyor rmacy label, DSP #8 and the MAR and then ore drops in each ear. 7 AM, review of Client #2's ARs (February 2019) showed rops 6.5%. Instill 5 drops in every month for cerumen every the facility failed to 's ear drops were	W 369	The TME will be retrained medication administration to include reading the physheet, the MAR and the procession of the physheet of the management of the physheet of the physh	n procedure ysician order pharmacy label will monitor the

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: HFD03-0095 B. WING 02/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC. WASHINGTON, DC 20008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 1 000 INITIAL COMMENTS 1000 A licensure survey was conducted from 02/06/19 through 02/08/19. Three residents were selected from a population of six men with intellectual disabilities. A fourth person, Resident #5, was added for a focused review of the resident's nutritional needs. 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. % - Percent DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities IPP - Individual Program Plan QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse 1222 3510.3 STAFF TRAINING 1222 QIDP has provided training for DSP# 16 on Client #2 feeding protocol. All DSPs There shall be continuous, ongoing in-service will receive training on Client #2 feeding training programs scheduled for all personnel. protocol. QIDP/Nursing Staff will continue to monitor documentation and implementation of feeding protocol. This Statute is not met as evidenced by: 2/28/19 Based on observation, record review and staff interview, the facility failed to ensure that each resident's mealtime protocol was implemented consistently for one of three residents in the sample (Resident #2). Findings included: On 02/06/19 at 3:45 PM, Resident #2 was observed drinking Ensure as he sat in the living Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRÉSENTATIVE'S SIGNATURE

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRÉSENTATIVE'S SIGNATURE

Program D'ucitor 3/6/19

STATE FORM

STATE

Health	Regulation & Licensia	ng Administration			FORM APPROVED
	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED
		HFD03-0095	B WING_	The state of the s	02/08/2019
NAME O	F PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	, STATE, ZIP CODE	
сомм	UNITY MULTI SERVICE	S, INC WASHING	GTON, DC	20008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
1 22:	2 Continued From pa	ge 1	1 222		
	macaroni salad, bro #2 refused to eat his living room at 5:36 F On 02/07/19 at 11:2 mealtime protocol d revealed staff should breakfast and dinne On 02/07/19 at 11:4 in-service training rereceived training on protocol on 01/09/19 During an interview of	7 AM review of Resident #2's ated 07/03/18 revealed d offer ensure two hours after r. 6 AM, review of the staff cords showed that all staff Resident #2's mealtime			
l 229	protocol. DSP #16 si receives his Ensure At the time of the sure that the training on R protocol had not bee 3510.5(f) STAFF TR Each training programal limited to, the following (f) Specialty areas refresidents to be served to, behavior manager	tated that Resident #2 two hours after his meal. Tvey, observations revealed tesident #2's mealtime in effective. AINING The shall include, but not be	l 229		
:	This Statute is not m Based on observation review, the GHIID fail	et as evidenced by: n, interview and record ed to ensure that each DSP provide one-to-one supports			£.

	Regulation & Licensin					
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:		SURVEY
		HFD03-0095	B. WING _		02/0	08/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE	1 02/0	70/2010
сомми	INITY MULTI SERVICE	S, INC	STON, DC	20008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
1 229	Continued From page	ge 2	1229			
	maintained current of System, for six of ei #3, 4, 5, 6, 10 and 1	certification in The Mandt ght one-to-one staff (DSPs 3).	Of Comments of the Comments of			
	Findings included:					
	was Resident #3's a during the overnight asked if the resident supports 24 hours, 7	AM, DSP #3 stated that she ssigned one-to-one staff shift. She replied "yes" when received one-to-one staffing days per week. Further the survey showed Residents ne-to-one staffing		All 1:1 DSP staff will be required to their Mandt certification prior to exp QIDP and QA will review personne records quarterly.	iration.	3/30/19
	personnel files revea received Mandt trainic certificates showed e since passed. At 1:00 Mandt training, the Quality training was required provide one-to-one since passed (DSPs #3, 4, 5 being one-to-ones an information from the long training was required to provide one-to-one and the long one-to-one and the long training training training training that the descriptions listed Market since was a since the long training trai	expiration dates that had DPM, when asked about alDP stated that Mandt for any staff assigned to supports. She identified eight 6, 6, 8, 10, 13 and 14) as and offered to seek current main office. In g at 2:10 PM, review of the DSP files: ir one-to-one job andt training as a		The QIDP will ensure that DSI 5,6, 10 and 13 will be retrained the next scheduled Mandt clas	din 🏻 🧍	3/30/19
	10 and 13 had obtained certification in the Mai No additional information and the survey end	ence that DSPs #3, 4, 5, 6, ed and/or maintained ndt System.				

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		HFD03-0095	B. WING _		02/08/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY	, STATE, ZIP CODE	
OMMU	NITY MULTI SERVICE	S, INC	GTON, DC	20008	
(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 APPI DEFICIENCY)	OULD BE COMPLET
1 229	maintained current of	ge 3 ith one-to-one supports had certification in The Mandt I in their job descriptions.	1 229		7
7	and assistance to re the resident 's Indivi This Statute is not n Based on observatio review, the GHIID staresident's physical fit was implemented at	provide habilitation, training sidents in accordance with idual Habilitation Plan. net as evidenced by: on, interview, and record aff failed to ensure that each tness and exercise program the recommended of three residents in the core	1422	The QIDP will review the acgoals for both day program for clients in home to ensure as stated in the ISPs recept QIDP will monitor for accuradocumentation for Client #1 staff will be retrained on Client active treatment goals.	and residential e implementation ive to each. ite and proper . All DSP
	Resident #1 sitting in television was on the extended his hand wi Resident #1 appeare resident, who stayed that day, was observe	AM, observations showed the living room while the news channel. The resident hen greeted by the surveyor. d to be non-verbal. The home from his day program ed leaving the facility at who said they were going munity.			
t c a ir F	he residents' IPPs. Fobjective (IPP dated 1 [Resident's name] will be civilty with a Direct Sondependently for 30 retriber review reveals upport Professionals	P provided the surveyor with Resident #1 had an exercise 12/06/18) that stated: Il participate in an exercise Support Professional minutes 5 days a week." ed the following: "Direct is will encourage [resident's rcise bike/treadmill, do			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0095	B. WING		02/08/2019
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
COMMUNITY MULTI SERVICE	ES, INC WASHIN	GTON, DC 20	008	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
The resident had si both his day progra residential IPP.] Continued observat #11 tapped on Resi they were going for immediately turned and went out the from Resident #1 was obtain with others at 5:05 for 100 (100 (100 (100 (100 (100 (100 (100	for community walks." [Note: milar exercise objectives in m IPP as well as his miles showed at 4:15 PM, DSP dent #1's shoulder and said a walk. The resident off his radio, grabbed his coat ont door with DSP #11. served reentering the facility PM. ing at 4:20 PM, review of remance data sheets for his evealed staff had documented dancing, bike riding, walking of exercise on 10 of 31 days; acks or other exercises on 8 esident #1 did not meet the er month. AM, the QIDP and RN were in that been recommended by od health and weight tiDP concurred, adding that enefit from staying fit in that enefit from staying fit in the house. Immediate review ition assessment (dated)		OCT INTERW	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DAT	(X3) DATE SURVEY COMPLETED		
	·	HFD03-0095	B. WING	B. WING		02/08/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET	ODRESS, CITY, S	TATE, ZIP CODE			
СОММО	NITY MULTI SERVICE	S, INC	GTON, DC 20	noa			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
1 422	Continued From pa	ge 5	1 422			1	
	at approximately 5:0 staff had document	e exit conference on 02/08/19 00 PM, it was pointed out that ed indoor exercises, such as bike and/or dancing to music	Î			3	
	ensure that Residen	rvey, the facility failed to at #1's exercise objective was recommended frequency.					
1						1	
						8:	
						f) f)	
1							
						0	
					9		
27					1		
					X		
		1 9.					
		i					

PRINTED: 02/25/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G037	B. WING	· ivida	02/08/2019		
	PROVIDER OR SUPPLIEF NITY MULTI SERVIC	ES, INC		REET ADDRESS, CITY, STATE, ZIP			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
E 000	Initial Comments		E 000			The same of the sa	
	An emergency pre- conducted from 02	eparedness survey was 2/06/19 through 02/08/19.	1				
	The findings of the interviews and revi preparedness prog	survey were based on lew of the emergency gram.					
	Note: The below a appear throughout	re abbreviations that may the body of this report.				Ç Y	
	PEP - Personal Em	tellectual Disabilities					
E 006	Plan Based on All F CFR(s): 483.475(a)	fazards Risk Assessment (1)-(2)	E 006			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
1	and maintain an em hat must be review	n. The [facility] must develop nergency preparedness plan red, and updated at least must do the following:]					
f	acility-based and co	d include a documented, ommunity-based risk g an all-hazards approach.*					
c	on and include a doc community-based ris	at §483.73(a)(1):] (1) Be based cumented, facility-based and sk assessment, utilizing an h, including missing residents.			:		
a	nd include a docum ommunity-based ris	33.475(a)(1):] (1) Be based on nented, facility-based and sk assessment, utilizing an n, including missing clients.			4		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y9WI11

Facility ID: 09G037

		E & MEDICAID SERVICES			MB NC	0. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED	
		09G037	B. WING_		02	2/08/2019
NAME OF	PROVIDER OR SUPPLIER	**************************************	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	100/2019
COMMU	INITY MULTI SERVICE	ES, INC		WASHINGTON, DC 20008		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(XS) COMPLETION DATE
E 006	Continued From pa (2) Include strategi	es for addressing emergency	E 006			1
	* [For Hospices at § strategies for addre identified by the risk management of the failures, natural disathat would affect the care.	the risk assessment. [3418.113(a)(2):] (2) Include essing emergency events cassessment, including the consequences of power asters, and other emergencies e hospice's ability to provide another as evidenced by:		CMS Program Director will de and implement a policy on Civ Disturbance.		3/15/19
	Based on interview failed to establish er each hazard identific	and record review, the facility mergency plans to address ed in the RA, for six of six e facility (Client #1, 2, 3, 4, 5		QIDP will train staff on the Civi Disturbance Policy for the residence and develop a so for staff to respond. An analysi completed and documented.	dential enario	
1	Findings Included:					1
	beginning at 3:20 PN facility's RA had ider	with the QIDP on 02/07/19, M, the QIDP stated that the ntified snow storm, flood and as the greatest potential				
1	facility's RA (not date	termined to be one of the			1	
t e	he facility's EPP date	ing at 11:30 AM, review of ed August 2018, showed no ility had established a plan ivil disturbance.			-	
F	PM, the QIDP acknow	terview on 02/08/19 at 3:14 wledged that there were no ddress the aforementioned	3			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY
		09G037	B. WING			2/08/2019
	PROVIDER OR SUPPLIER NITY MULTI SERVICE	S, INC		STREET ADDRESS, CITY, STATE, ZIP CO WASHINGTON, DC 20008	DOE	70072019
(X4) ID PREFIX TAG	[(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	[(a) Emergency Plat and maintain an em that must be review annually. The plan reservices the [facility] an emergency; and including delegations plans.** *Note: ["Persons at rhospice, PACE, HHAFQHC, or ESRD factor or	n. The [facility] must develop ergency preparedness plan ed, and updated at least must do the following:] client population, including, rsons at-risk; the type of has the ability to provide in continuity of operations, s of authority and succession isk" does not apply to: ASC, CORF, CMCH, RHC, lities.] not met as evidenced by: and record review, the facility id to address the most sk assessment for two of six if facility (Clients #2 and 3). In 02/07/19 at 3:38 PM, the idetermined that Client #2 is that would be "especially at ency due to the client's estaff, gait belt, and risk for also at risk due to his need	E 007		eir personal after an raining on	3/15/19
E ti ri	EPP and the client's F he plan failed to addr isks for Client #2 and	g at 10:43 AM, review of the PEP (not dated), revealed ess the aforementioned 3.	To the second se		Acceptance (Calaborate Calaborate	

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

OTATELAS		The Day William			OIMP MC	7. 0938-0391
AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1			A BUILDING		(0)	MPLETED
		09G037	B. WING		0.7	/08/2019
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02	10012019
СОММ	UNITY MULTI SERVICE	ES, INC	1	WASHINGTON, DC 20008		
(X4) ID	SUMMARY STA	NTEMENT OF DEFICIENCIES		T		,
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 007	7 Continued From pa	ae 3	E 007			
		n failed to address Clients #2	E 007			1
	and 3 most vulnera	ble risks				
						1
	At the time of the su	urvey, the facility failed to				8
	identified risk to an	and/or PEP included the sure client's health and safety				
	during and after an	emergency.				
E 039	EP Testing Requirer	ments	E 039			
	CFR(s): 483.475(d)	(2)		e. H		
	(2) Testing The Ifoc	ility, except for LTC facilities,				
	RNHCIs and OPOst	must conduct exercises to				1
	test the emergency	plan at least annually. The				
	[facility, except for R	NHCIs and OPOs] must do				00.
	all of the following:					1:
	*[For LTC Facilities a	at §483.73(d):] (2) Testing.	14			
	The LTC facility mus	t conduct exercises to test		QIDP will coordinate with CMS	3 Progr	am
	the emergency plan	at least annually, including	1	Director to organize and plan	a facility	y
	procedures The LTC	rills using the emergency c facility must do all of the		pased exercise to include a ta and complete an analysis of th	pietop/	arilis
	following:]	racinty must do all of the		facility's response to the exerc		3/29/19
	i	*		and the species to the exerc		0/20/10
	(i) Participate in a ful	l-scale exercise that is			±	
	exercise is not acces	when a community-based				1
	facility-based. If the	[facility] experiences an				
	actual natural or man	-made emergency that				
	requires activation of	the emergency plan, the			1	İ
	[facility] is exempt fro	m engaging in a			į	
	full-scale exercise for	individual, facility-based 1 year following the onset of			Ē	
	the actual event.	year following the onset of				
	(ii) Conduct an addition	onal exercise that may			1	
	include, but is not limi	ited to the following:			- 1	
	(A) A second full-so	cale exercise that is			/4	
	community-based or i	individual, facility-based.	4		1	
	(b) w rapietob exer	cise that includes a group				

	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-03				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED		
		09G037	B WING_		02	2/08/2019		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE			
COMMU	NITY MULTI SERVICE			WASHINGTON, DC 20008				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE		
f	clinically-relevant exprepared questions emergency plan. (iii) Analyze the [facination documents exercises, and emergency elast annually. A tab discussion led by a following: (i) Conduct a paper least annually. A tab discussion led by a following: (ii) Conduct a paper least annually. A tab discussion led by a following: (ii) Conduct a paper least annually. A tab discussion led by a following: (ii) Analyze the [RNI to and maintain doct exercises, and emergency plan. (iii) Analyze the [RNI to and maintain doct exercises, and emergency exercises and emergency exercises and emergency exercises and emergency exercises. This STANDARD is Based on record revision of a facility-based exercises in the facility	facilitator, using a narrated, mergency scenario, and a set ints, directed messages, or designed to challenge an illity's] response to and ation of all drills, tabletop regency events, and revise the y plan, as needed. 3.748 and OPOs at sting. The [RNHCl and OPO] isses to test the emergency and OPO] must do the interpretable to the emergency scenario, and a set ints, directed messages, or designed to challenge an interpretable to challenge an interpretable to gency events, and revise the interpretable emergency plan, as interpretable emergency plan, as interpretable encise with outside sources ercise, for six of six clients (Clients #1, 2, 3, 4, 5 and	E 03	39				
_ fa	ייט טענטייט טענטייט טענטייט טענטייט טענטייט טענטייט טענער טענער טענער טענער טענער טענער טענער טענער טענער טענע acility's EPP (not dat	ed) showed no evidence			1			

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G037	B. WING		0.2	10010040
NAME OF	PROVIDER OR SUPPLIER	The state of the s	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	/08/2019
сомми	NITY MULTI SERVICI	ES, INC	W	/ASHINGTON, DC 20008		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Continued From page 5 that the facility had participated in a full-scale community based exercise or a facility-based exercise. Drill reports indicated however, that facility staff had engaged in a "tabletop activity" on 07/02/2018. On 02/08/19 at 3:03 PM, the QIDP confirmed that the facility had not participated in a full-scale community based exercise or a facility-based exercise. She stated that the director had reached out to several outside sources (i.e. fire department, recreation centers and other group homes) about coordinating a full-scale exercise with the facility and there was one such exercise being planned for 04/2019. The QIDP said that on 07/02/18, staff watched a video on how to respond to an Active Shooter scenario and discussed the topic afterwards. The QIDP acknowledged that the training session on Active Shooter did not constitute a facility-based		E 039	E 039		
	At the time of the su conduct emergency emergency plan.	rvey, the facility failed to exercises to test the				
			10			
					i	
2						
					q	
1.		a.			1	
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1					-	