STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G223	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	6217 16TH STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

Received 7/11/19 cw

W 000 INITIAL COMMENTS

A recertification survey was conducted from 06/11/19 to 06/12/19. A sample of two clients was selected from three males and one female. 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:

DSP - Direct Support Professional

W 247 INDIVIDUAL PROGRAM PLAN
CFR(s): 483.440(c)(6)(vi)

The individual program plan must include opportunities for client choice and self-management.
This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to consistently promote client self-management during breakfast, snack and dinner time, for four of four clients residing in the facility (Clients #1, 2, 3 and 4).

Findings included:

On 06/11/19 beginning at 6:12 AM, observations showed the following:

- At 7:37 AM, Client #1 entered the dining room with DSP #4. The client sat at the dining table. At 7:41 AM, DSP #4 was observed picking up a container of milk and pouring milk into four beverage glasses, one for each client.

W 000

W 247 The facility's Social Worker and QIDP will retrain facility staff on consistently promoting all clients on self-management during meals/snacks and other tasks performed independently to the full extent of his or her capabilities.
QIDP will monitor weekly for proper implementation of all staff. 7/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance A. Reese	Program Director	7/11/19

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 247	Continued From page 1	W 247		

- At 2:29 PM, Client #2 was in the kitchen washing his lunch tupperware out independently.

- At 2:31 PM, DSP #7 placed green plate mats and bowls onto the dining table for Clients #1, 2, 3 and 4.

- At 2:36 PM, DSP #7 placed chips into Clients #1 and 2's bowls. DSP #7 poured milk into Client #4's cup. DSP #7 also poured juice and water into Clients #1 and 2's cups.

- At 2:40 PM, Client #4 finished a snack, retrieved the cup, bowl, place mat and took them to the kitchen sink.

- At 2:50 PM, Client #1 took the place mat, bowl and cup to the kitchen sink. DSP #7 placed chips inside Client #3's bowl for a snack.

- At 2:57 PM, Client #2 took the place mat, bowl and cup to kitchen sink. Client #2 turned on the water, washed the cup/bowl and placed the cup/bowl on the dish rack.

- At 3:06 PM, Client #3 took the place mat, bowl and cup to kitchen sink. Client #3 turned on the water, washed the cup/bowl and placed the cup/bowl on the dish rack.

- At 3:15 PM, Client #2 used a remote to change from watching the digital versatile disc player to watching the daytime talk show "Ellen" independently.

- At 3:42 PM, Client #3 was in the living room folding clothes.

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W 247	Continued From page 2	W 247		

- 4:54 PM, Client #1 independently placed a place mat, fork, spoon and napkin at the location the client would soon eat dinner.

- 5:00 PM, DSP #12 poured milk into Clients #1, 2 and 3's cups during dinner time. Client #3 poured water into Clients #2, 3 and 4's cups.

- At 5:07 PM, Clients #1, 2, 3 and 4 served themselves barbecue chicken, salad and noodles during family style dining. The clients' all ate their dinner independently after set-up.

- At 6:25 PM, Client #4 poured water into a cup independently during medication administration.

On 06/11/19 at 3:35 PM, DSP #7 said during an interview that Clients #1, 2, 3 and 4 can set or participate in setting the table during breakfast, snack and dinner time. DSP #7 indicated that the clients could pour their own beverages in their cups, retrieve the place mats, cups, plates, eating utensils from the kitchen and served themselves independently. When queried about why were the clients not encouraged or giving the opportunity to set the table and pour their own beverages, DSP #7 said the clients are usually tired after coming home from their day programs. DSP #7 then stated that's the reason she fixed their snacks and set the table for them during snack time.

At the time of the survey, the facility's staff failed to allow Clients #1, 2, 3 and 4 to exercise their independence during breakfast, snack and dinner time to the full extent of his or her capabilities.

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E 000	Initial Comments An emergency preparedness survey was conducted from 06/11/19 through 06/12/19. 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. EP - Emergency Preparedness EPP - Emergency Preparedness Plan QIDP - Qualified Intellectual Disabilities Professional	E 000		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a	E 009	The facility's Program Director will provide additional information in the Communication Plans Policy/Procedure to include and enable the facility to collaborate with local/state/federal authorities during a disaster and emergency situation. An Emergency Preparedness contact list will be utilized in efforts to ensure an immediate and integrated response.	7/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance C. Reese	Program Director	7/11/19

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E 009	Continued From page 1 disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on the review of documents and interview with facility staff, the facility failed to show documentation of efforts relevant to the process for ensuring cooperation and collaboration with local, regional, state and federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 06/12/19 beginning at 12:31 PM, review of the facility's EPP, updated on 05/08/19, showed no evidence that the facility collaborated with local, regional, state and federal EP officials to ensure an integrated response during a disaster or emergency situation. At 1:39 PM, the QIDP confirmed during an interview that he had not reached out to any state or federal officials regarding emergency planning. At the time of the survey, there was no evidence that the facility documented efforts to reach out to local, regional, state and federal EP officials for collaborative and cooperative planning efforts to ensure an integrated response during a disaster and/or emergency.	E 009		

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E 039	EP Testing Requirements CFR(s): 483.475(d)(2)	E 039		

(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:

*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

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E 039	Continued From page 3	E 039		

*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community-based exercise with outside sources, for four of four clients residing in the facility (Clients #1, 2, 3 and 4).

Findings included:

On 06/11/19 at 9:20 AM, the EP leader (QIDP) agreed to make available for review all documentation pertaining to the facility's EPP.

On 06/12/19 beginning at 12:37 PM, review of the facility's EPP (updated 05/08/19) showed that the facility did not participate in a full-scale community-based exercise to present.

When interviewed on 06/12/19 at 1:00 PM, the QIDP said that the team had a meeting to brainstorm about conducting a full-scale

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E 039	Continued From page 4 community-based exercise. When asked if he had reached out to other providers and/or outside sources to identify a full-scale community based exercise, the QIDP said that he had not. At the time of the survey, the facility failed to show evidence that it attempted to identify a full-scale community-based exercise.	E 039	The QIDP/Program Director will contact other providers and/or outside sources to identify a full scale community base exercise that this facility can participate in along with other CMS facilities. 7/31/19	

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	HFD03-0251	A. BUILDING: _____ B. WING _____	06/12/2019

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I 000	INITIAL COMMENTS A licensure survey was conducted from 06/11/19 to 06/12/19. A sample of two residents was selected from three men and one woman. 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. GHIID - Group Home for Individuals with Intellectual Disabilities LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional	I 000		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that each employee had a current health certificate on file, for one of two nurses observed in the facility during the survey (the LPN). Findings included: On 06/12/19 at 8:55 AM, the QIDP introduced the	I 206	The facility's LPN health certificate was obtained and currently on file. QIDP/QA will monitor personnel records quarterly.	6/14/19

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I 206	Continued From page 1 surveyor to an LPN. The LPN stated that she had just finished administering medications to all four residents of the facility. On 06/12/19 at 3:13 PM, review of the personnel file maintained for the LPN showed no evidence of a health certificate. The QIDP telephoned the main office and was informed that the LPN had been summoned to the office that afternoon. He further stated that the most recent physical examination was documented on 05/18/18. At the time of the survey, the facility failed to show evidence that they had implemented a system that ensures that every employee working with the residents obtained an annual health screening.	I 206		