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	09G223	A. BUILDING ______ B. WING ______	08/30/2018

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COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20012

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W 000 INITIAL COMMENTS — W 000

A recertification survey was conducted from 08/28/18 through 08/30/18. Two clients were selected from a population of one female and three males with various degrees of intellectual disabilities. This survey was conducted utilizing 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.

DON - Direct of Nursing
LPN - Licensed Practical Nurse
MG - Milligram
PCP - Primary Care Physician
POS - Physician's Order Sheets
PO - Physician Order
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse
BSP - Behavior Support Plan
IPP - Individualized Program Plan
TID - Three times a day
BID - Two times a day
MAR - Medication Administration Record

W 239 INDIVIDUAL PROGRAM PLAN — W 239
CFR(s): 483.440(c)(5)(vi)

Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 10/5/18

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 239	Continued From page 1 appropriate. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a training program that provided specific interventions to manage a client's use of a toothbrush in an unsanitary manner for one (1) of the two (2) clients in the sample (Client #1). Findings included: On 08/28/18 at 8:57 AM, Client #1 was observe holding his toothbrush as he sat at the dining room table. At approximately 9:00 AM, Client #1 placed his toothbrush in his pocket. At 10:48 AM, Client #1 was observed at his day program. Client #1 was sitting at the table holding his toothbrush. At 10:58 AM, the day program staff stated that Client #1 likes to hold his toothbrush and will go into the bathroom to brush his teeth. When asked, the day program staff stated that the client does not have a toothbrush holder. At 3:23 PM, Client #1 arrived home from his day program. At 3:44 PM Client #1 was observe riding his stationary bike as he held his toothbrush. On 08/29/18 beginning at 9:29 AM, review of Client #1's IPP and BSP revealed the plan failed to address Client #1's behavior of walking around with his toothbrush in his hand. Interview with the QIDP on 08/29/18 at 2:00 PM, revealed Client #1 behavior of walking around with his toothbrush in a unsanitary manner was not addressed. At the time of survey, the facility failed to	W 239	Psychologist will update BSP to address the target behavior and intervention to manage client's use of a toothbrush in a sanitary manner. The staff will receive training from the psychologist.	10/19/18

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W 239	Continued From page 2 incorporate interventions to address Client #1's behavior.	W 239		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the nursing staff obtained timely fungal nail culture results for one (1) of two (2) clients in the sample (Client #1). Findings included: During the morning medication pass on 08/29/18, at 7:27 AM, Client #1 was wearing an open toe shoe. Observation of the client's toe nails revealed all ten toe nails were long. On 08/29/18, at 9:49 AM, review of Client #1's podiatry consult dated 06/11/18, revealed a fungal nail culture was performed. The consult stated "report to follow." However, there was no documented evidence the results of the culture test was obtained by the facility. During an interview with the DON on 08/30/18, at approximately 2:00 PM, the DON stated that she had the report at a different location and she needed to call the podiatrist for clarity. At the time of the survey, the nursing staff failed to obtain a culture report from the podiatrist	W 322	The culture result was collected from the podiatrist's office by the RN. In the future, the nursing staff will review all medical reports and follow with the recommendations. All medical service sheets will be reviewed and signed by the nurse. The nurse is responsible to collect all results. The nursing staff wil receive additional training on medical reports and recommendations.	10/19/18

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W 322	Continued From page 3 timely.	W 322		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff (I) failed to ensure that each Client's medication for Prozac was ordered, (II) failed to ensure an order for Brimonidine was available during medication administration for two (2) of four (4) clients residing in the facility (Client #1 and 4). Findings included: 1. On 08/28/18, beginning at 8:47 AM, Client #1 was observed uttering profanity, using inappropriate language and was observed talking to himself. Client #1 was observed at his day program beginning at 10:48 AM talking to himself. At 10:53 AM, the day program staff encouraged Client #1 to participate in a game of bingo with his peers and staff, but he refused and continued to talk to himself. On 08/29/18, at 10:03 AM, review of Client #1's Psychiatry Assessment dated 06/01/18, revealed a recommendation to "add Prozac 40 mg daily and continue Seroquel." On 08/29/18, beginning at 10:15 AM., review of Client #1's MAR and POS book failed to reveal an order for Prozac.	W 331	The nursing staff will be retrained on reviewing all medical reports and follow up with the recommendations on time. The DON will review medical records on a quarterly basis for compliance.	10/18/18

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W 331	Continued From page 4 On 08/29/18, at 11:55 AM, interview with the QIDP revealed Client #1 did not start his Prozac because it was not presented to the human rights committee. On 08/30/18, at 9:44 AM, interview with the DON revealed Client #1's Prozac should have been ordered within a couple of days after the psychiatrist prescribed the Prozac. At the time of the survey, the facility's nursing services failed to ensure Client #1's medication for Prozac was ordered as recommended by the psychiatrist.	W 331		
	2. (Cross Reference W388) On 08/28/18, beginning at 5:27 PM, the LPN was observed administering Brimonidine eye drops into Client #4's eyes.		The nursing staff obtained the copy of the physician order sheet from the pharmacy.	10/3/18
	On 08/28/18, beginning at 6:15 PM, review of Client #4's MAR and POS book failed to reveal an order for Brimonidine eye drops. On 08/28/18, at 6:20 PM, the LPN reviewed the MAR and the POS book for the aforementioned order. At 6:24 PM, the LPN stated that she was not able find the order for the Brimonidine eye drop. On 08/29/18, at 9:44 AM, the QIDP presented an order for the aforementioned medication dated 03/02/17. It was then reviewed by the surveyor to ensure that the medication administered was in accordance with the PO. At the time of the survey, the facility's nursing services failed to ensure Client #4's order for Brimonidine was maintained and available for		The nursing staff will be retrained on reviewing physician order sheet, pharmacy label and MAR for consistency. DON will monitor for compliance.	10/18/18

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W 331	Continued From page 5 review prior to medication administration.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered in accordance with physician's orders, for one (1)of four (4) clients receiving medications (Client #3). Findings included: On 08/28/18, beginning at 5:13 PM, during the evening medication administration, the LPN was observed preparing Client #3's medications. At 5:18 PM, Client #3 administered his Tamsulosin after the LPN handed the medication to him. During this time, review of the label on the medication container showed instructions to give the medication 30 minutes after eating. However, Client #3 was observed eating his dinner at 6:03 PM, after his medication was administered. On 08/28/18, at 6:15 PM review of the POS, dated 08/01/18, showed an order for Tamsulosin 0.4 mg. The order stated to take "1 capsule by mouth every day 30 minutes after the same meal each day." Interview with the DON on 08/29/18, at 9:50 AM, confirmed that Client #3 should have received the	W 368	The nursing staff will be retrained on reviewing physician order sheet to adhere to the time restriction. The DON will monitor the MAR for compliance quarterly.	10/18/18

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W 368	Continued From page 6 aforementioned medication 30 minutes after his meal. At the time of the survey, the facility failed to ensure Client #3 received Tamsulosin 0.4 mg capsule 30 minutes after his dinner as prescribed.	W 368		
W 388	DRUG LABELING CFR(s): 483.460(m)(1)(i) Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the pharmacist labeled each bottle of Brimonidine in accordance with each physician order, for one (1) of four (4) clients receiving medications (Client #4). Findings included: On 08/28/18, at 5:27 PM, the LPN instilled one drop of Brimonidine into Client #4's left eye. During the verification process, it was discovered that the label on the bottle of the Brimonidine eye drop stated, "instill one drop in both eyes TID." Further verification failed to show an order for the aforementioned medication. On 08/28/18, at 6:20 PM, the LPN stated that the label for the Brimonidine eye drop was incorrect. The LPN then reviewed the MAR and the POS book for the aforementioned order. At 6:24 PM, the LPN stated that she was not able find the	W 388	The order for the identified eye drops was collected from the pharmacy and placed in the MAR book. Primary nurse will monitor for compliance monthly. The nursing staff will be retrained on the importance of obtaining physician order sheet for each medication administered. Primary Care nurse will monitor for compliance monthly.	10/3/18 10/19/18

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W 388	Continued From page 7 order for the Brimonidine eye drop. On 08/29/18, at 9:44 AM, the QIDP presented an order for the aforementioned medication. According to a physician's order dated 03/02/17, one drop of Brimonidine was to be administered in the left eye BID. At 9:45 AM, the DON confirmed that the label was incorrect. The DON stated that she would obtain the correct label for the Brimonidine eye drop. At the time of survey, the facility failed to ensure that all prescribed medications were labeled in accordance with the physician order.	W 388		

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I 000	INITIAL COMMENTS A licensure survey was conducted from 08/28/18 through 08/30/18. Two residents were selected from a population of one female and three males with various degrees of intellectual disabilities. 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 DON - Direct of Nursing LPN - Licensed Practical Nurse MG - Milligram PCP - Primary Care Physician POS - Physician's Order Sheets PO - Physician Order QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse BSP - Behavior Support Plan IPP - Individualized Program Plan TID - Three times a day BID - Two times a day MAR - Medication Administration Record	I 000		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.	I 401		

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I 401	Continued From page 1 This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHIID nursing staff (I) failed to ensure that each Resident's medication for Prozac was ordered, (II) failed to ensure an order for Brimonidine was available during medication administration for two (2) of four (4) residents residing in the facility (Resident #1 and 4). Findings included: 1. On 08/28/18, beginning at 8:47 AM, Resident #1 was observed uttering profanity, using inappropriate language and was observed talking to himself. Resident #1 was observed at his day program beginning at 10:48 AM talking to himself. At 10:53 AM, the day program staff encouraged Resident #1 to participate in a game of bingo with his peers and staff, but he refused and continued to talk to himself. On 08/29/18, at 10:03 AM, review of Resident #1's Psychiatry Assessment dated 06/01/18, revealed a recommendation to "add Prozac 40 mg daily and continue Seroquel." On 08/29/18, beginning at 10:15 AM., review of Resident #1's MAR and POS book failed to reveal an order for Prozac. On 08/29/18, at 11:55 AM, interview with the QIDP revealed Resident #1 did not start his Prozac because it was not presented to the human rights committee. On 08/30/18, at 9:44 AM, interview with the DON revealed Resident #1's Prozac should have been ordered within a couple of days after the psychiatrist prescribed the Prozac.	I 401	The prozac was started on 9/6/18. The nursing staff will be retrained on reviewing all physician orders/medical reports and recommendations on time. The DON will review medical records for compliance quarterly.	10/19/18 10/19/18

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I 401	Continued From page 2 At the time of the survey, the facility's nursing services failed to ensure Resident #1's medication for Prozac was ordered as recommended by the psychiatrist. 2. (Cross Reference W388) On 08/28/18, beginning at 5:27 PM, the LPN was observed administering Brimonidine eye drops into Resident #4's eyes. On 08/28/18, beginning at 6:15 PM, review of Resident #4's MAR and POS book failed to reveal an order for Brimonidine eye drops. On 08/28/18, at 6:20 PM, the LPN reviewed the MAR and the POS book for the aforementioned order. At 6:24 PM, the LPN stated that she was not able find the order for the Brimonidine eye drop. On 08/29/18, at 9:44 AM, the QIDP presented an order for the aforementioned medication dated 03/02/17. It was then reviewed by the surveyor to ensure that the medication administered was in accordance with the PO. At the time of the survey, the facility's nursing services failed to ensure Resident #4's order for Brimonidine was maintained and available for review prior to medication administration.	I 401	The order for the identified eye drops was collected from the pharmacy and placed in the MAR book. Primary nurse will monitor for compliance monthly. The nursing staff will be retrained on the importance of obtaining physician order sheet for each medication administered. Primary Care nurse will monitor for compliance monthly.	10/3/18 10/19/18

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E 000	Initial Comments An emergency preparedness survey was conducted from 08/28/18 through 08/30/18. 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. EPP - Emergency Preparedness Program QIDP - Qualified Intellectual Disabilities Professional RA - Risk Assessment RN - Registered Nurse	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 and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E 006	The facility's QIDP has contacted each Day Program and requested a meeting to review their Emergency Preparedness Plan and Missing Person Policy and to request a copy.	10/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese
TITLE: Program Director
(X6) DATE: 10/5/18

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E 006 Continued From page 1

(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 (I) failed to collaborate with each client's day program to determine what arrangements where necessary to ensure that essential services could be provided during an emergency; (II) failed to establish emergency plans to address some of the hazards identified in the RA and (III) failed to establish emergency plans to address situations when clients are in the community for four (4) of four (4) clients residing in the facility (Client #1, 2, 3 and 4).

Findings included:

(I) On 08/29/18, beginning at 4:05 PM, review of the facility's EPP dated 11/22/17 showed a lack of collaboration with the clients day programs to ensure that essential services would be provided in the event of an emergency.

On 08/30/18, at 3:39 PM, the QIDP was asked during an interview if the facility coordinated with the clients' day programs to develop an EPP for when their at their day programs. The QIDP said "no" we did not include the clients' day programs into the development of the EPP based on the RA.

E 006 The facility will update the Risk Assessment to address all hazards that are identified as a significant threat to include a missing person policy. The policies will be reviewed annually and updated by the Program Director. 10/19/18

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(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
E 006	Continued From page 2	E 006		

At the time of the survey, the facility failed to coordinate with the day programs to develop a plan for when clients' are at their day program during an emergency.

(II) On 08/29/18, beginning at 4:05 PM, review of the facility's EPP dated 11/22/17, showed no planning for emergency events that might occur while the clients were in the community.

During an interview on 08/30/18 at 3:42 PM, the QIDP acknowledged that the EPP failed to provide guidance for situations such as if a tornado warning was issued while the clients were engaged in a community outing.

At the time of the survey, the facility failed to ensure that the EPP addressed emergency situations when clients were away from the facility.

(III) During an interview with the QIDP on 08/29/18 beginning at 2:55 PM, the QIDP stated that the facility's RA had identified snowstorms, hurricanes, tornados and thunderstorms as the greatest potential hazards. The QIDP then added ice storms, blizzards, earthquakes, extreme heat, drought and wild fires as posing lesser degrees of risk.

On 08/29/18 beginning at 3:38 PM, review of the facility's RA, dated 11/22/17, showed "Supply Shortage" was determined to be of highest overall risk (at 61%). The next-greatest hazards listed were "Electrical Failure" and "Communications Failure" (at 56%). The RA showed the risk of "Information System Failure and Mass Casualty" was 44%, "Fuel Shortage, Fire, Flood, Structural Damage and Civil Disturbance" was 41% ,

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 ______	08/30/2018

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COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20012

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E 006	Continued From page 3 "Missing Resident" was 39%, "Generator Failure" and "Transportation Failure" was 37%, "Severe Thunderstorm" 33%, and the risk of "Snow Fall " and "Blizzard" was 28%. On 08/29/18 beginning at 3:55 PM, review of the facility's EPP, dated 11/22/17, showed no evidence that the facility had established plans on how to address missing clients, transportation failure, structural damage, mass casualty incidents, Fuel Shortage, or civil disturbances. During a follow-up interview on 08/30/18 at 2:30 PM, the QIDP acknowledged that there were no plans developed to address the aforementioned identified risks.	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	E 007		

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E 007	Continued From page 4 determined to be the most vulnerable in the risk assessment four (4) of 4 clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: During an interview on on 08/29/18, at 2:55 PM, the QIDP stated that they had determined that Client #2 would be "especially at risk" during an emergency due to the client's weight, slow mobility and fall risk. The second most "at risk" client was Client #4 due to seizures and noncompliance. The third most "at risk" client was Client #1 due noncompliance and resistance to listening to women.	E 007		
	On 08/28/18, beginning at 3:55 PM, review of the facility's EPP, dated 11/22/17, and Clients #2, 3 and 4 individualized EPP (not dated), revealed that neither plan reflected the aforementioned risk or the need to have an assigned one-to-one staff. Further review revealed an EPP was not developed for Client #1. On 08/30/18, beginning at approximately 2:58 PM, the QIDP examined the client's EPP. The QIDP acknowledged that the client's risk was not addressed in the EPP. In Addition, the QIDP stated that Client #1 did not have a plan. At the time of the survey, the facility's EPP failed to address vulnerable clients in the event of an emergency.		The facility's QIDP has revised the PEEP for Client #2, #3 and #4 to address each client's risks in the event of an emergency. The individualized PEEP for Client #1 will be developed, reviewed and signed by Client #1's guardian.	10/19/18 10/19/18
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness	E 035		

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E 035	Continued From page 5 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: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client's family member or representative had been given information regarding the facility's emergency plan, for one (1) of 4 clients residing in the facility (Client #1). Findings included: On 08/29/18, beginning at 4:05 PM, review of the facility's EPP dated 11/22/18 showed no evidence that the EPP was shared with Client #1's family members and/or guardians. On 08/30/18 at 3:50 PM, the QIDP said during an interview that an EPP for Client #1 had not been developed. The QIDP stated that the EPP would be developed and emailed to Client #1's family member and guardian. At the time of the survey, the facility failed to ensure the client's family members and/or guardians received an EPP for each client.	E 035	The facility will develop a written plan for the EPP that will contain methods within the Communication Plan that will give guidance for sharing information for the client's families or representatives during an emergency. The Program Director will review plan annually. QIDP made contact with family/guardian via email and received approval for Client #2, #3 and #4. Client #1 has been developed and approval from guardian will be completed.	9/25/18 10/12/18