STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G252	A. BUILDING _____ B. WING _____	09/21/2018

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COMMUNITY MULTI-SERVICES,INC	1701 24TH STREET, NE WASHINGTON, DC 20018

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E 000	Initial Comments An emergency preparedness survey was conducted from 09/19/18 through 09/21/18. 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 Plan QIDP - Qualified Intellectual Disabilities Professional RA - Risk Assessment CPAP - Continuous Positive Airway Pressure	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 collaborated with each person's day program and has requested a copy of their Emergency Evacuation Plan in the event the person is at the day program or in the community during an emergency/disaster.	11/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 10/29/18

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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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 situations when clients are in the community and (III) failed to establish emergency plans to address hazards identified in the RA for four of four clients residing in the facility (Client #1, 2, 3 and 4). Findings included: (I) On 09/21/18, beginning at 10:11 AM, review of the facility's EPP (November 2017) showed a lack of collaboration with the clients identified day programs to ensure that essential services would be provided in the event of an emergency. On 09/21/18, at 12:03 PM, the QIDP was asked during an interview if the facility coordinated with the clients' day programs to develop an EPP during an emergency event. The QIDP said there was not a plan in place with the day programs for emergency events. At the time of the survey, the facility failed to coordinate with the day programs to develop a	E 006		

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E 006	Continued From page 2 plan for when clients' are at their day program during an emergency. (II) On 09/21/18, beginning at 10:11 AM, review of the facility's EPP (November 2017) , showed no planning for emergency events that might occur while the clients were in the community. During an interview on 09/21/18 at 12:10 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 09/20/18 beginning at 4:26 PM, the QIDP stated that the facility's RA had identified snowstorms, hurricanes, thunderstorms and power outage as the greatest potential hazards. The QIDP then added Tornados, biohazards, civil disturbance and mass casualties as posing lesser degrees of risk. On 09/21/18, beginning at 10:11 AM, review of the facility's EPP (November 2017) , 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% , "Missing Resident" was 39%, "Generator Failure" and "Transportation	E 006	The facility's EPP will be revised and reviewed to include how to address transportation failure, structural damage, electrical failure, fuel shortage or civil disturbances in the event the persons are away from the facility.	11/16/18

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E 006	Continued From page 3 Failure" was 37%, "Severe Thunderstorm" 33%, and the risk of "Snow Fall " and "Blizzard" was 28%. On 09/21/18, beginning at 10:11 AM, review of the facility's EPP (November 2017) , showed no evidence that the facility had established plans on how to address transportation failure, structural damage, electrical failure, fuel shortage, or civil disturbances. During a follow-up interview on 09/21/18 at 11:56 AM, 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 determined to be the most vulnerable in the risk	E 007		

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E 007	Continued From page 4 assessment for two of five clients residing in the facility (Client #1 and 5). Findings included: During an interview on 09/20/18, at 4:38 PM, the QIDP stated that they had determined that Client #5 would be "especially at risk" during an emergency due to the client's impaired vision, Jevity via peg tube, and the need for CPAP machine. The second most "at risk" client was Client #1 due to his ambulation and the need to use a gait belt. On 09/21/18, beginning at 10:11 AM, review of the EPP (November 2017), revealed the plan failed to reflect the aforementioned risks for Clients #1 and #5. On 09/21/18, at approximately 12:30 PM, the QIDP acknowledged that the client's risk was not addressed in the EPP. At the time of the survey, the facility's EPP failed to address vulnerable clients in the event of an emergency.	E 007	The facility will revise and update the EPP to address issues and care for vulnerable clients in the event of an emergency.	11/16/18
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must	E 022		

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E 022	Continued From page 5	E 022		

address the following:]

(4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].

*[For Inpatient Hospices at §418.113(b):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(i) A means to shelter in place for patients, hospice employees who remain in the hospice.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to develop policies and procedures that address a means of sheltering in place for additional clients and staff in the facility during a disaster or emergency situations.

Findings included:

On 09/21/18, beginning at 10:11 AM, review of the facility's EPP (November 2017) showed no evidence that the facility had developed policies and procedures to address sheltering in place for additional clients and staff.

On 09/21/18, at 12:50 PM, the QIDP said during an interview that staff had been trained on what to do should staff and clients need to shelter in place for tornados, blizzard, hurricane, etc. The QIDP stated that other persons, such as clients and staff from other homes, could remain in the facility to shelter in place if/when needed. When asked if there were policies and procedures

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E 022	Continued From page 6 outlined in the EPP for when additional clients and staff are in the facility, the QIDP stated no after reviewing the EPP. At the time of the survey, there was no evidence that the facility developed policies and procedures in the EPP to address sheltering in place during emergencies and disasters for additional clients and staff.	E 022	The facility's EPP will be updated to address sheltering in place during emergencies and disasters for additional clients and staff.	11/16/18

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W 000	INITIAL COMMENTS A recertification survey was conducted from 09/19/18 through 09/21/18. Three clients were selected from a population of five men 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. DSP - Direct Support Professional LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional IPP - Individualized Program Plan MAR - Medication Administration Record	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that each client's mealtime protocol was implemented consistently for one of three clients in the sample (Client #1). Findings included:	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese | TITLE: Program Director | (X6) DATE: 10/29/18

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W 189	Continued From page 1 On 09/19/18 beginning at 5:20 PM, Client #1 was observed eating fish, macaroni and cheese, cabbage, carrots and bread at a fast pace. As Client #1 scooped his food with his teaspoon, DSP #1 used a butter knife to portion the food away from the client's spoon. At 5:26 PM Client #1 spilled his water as he drank at a fast pace. As the client drank, DSP #1 placed a bowl under the client's cup to catch the excess water that was spilling. On 09/20/18 beginning at 6:28 AM, Client #1 was observed eating cheerios and toast. During this time, DSP #2 touched Client #1's shoulder and asked him to wait each time he began to eat fast. Further observations showed DSP #2 held a cup of water to the client's mouth as he drank his water. Review of Client #1's mealtime protocol dated 07/24/18 at 9:41 AM, revealed the following: a. Provide 100% close supervision during all meals. b. Alternate solids and liquids during the meal. c. Ensure that his mouth is empty before the next spoonful. d. Allow one to two teaspoons per swallow. e. Provide verbal prompts as needed to encourage him to reduce his rate of PO intake. f. Avoid consecutive swallowing while drinking, for swallow safety and to minimize spillage.	W 189	DSP #1 and #2 received additional training on Client's #1 Mealtime Protocol by the QIDP and Nursing Staff. QIDP will monitor weekly for compliance.	10/29/18

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W 189	Continued From page 2 During an interview on 09/20/18, at 8:05 AM, DSP #2 confirmed that Client #1 has a feeding protocol. DSP #2 stated that he allows the client time to eat and he holds his cup to prevent spillage. On 09/21/18, at 3:05 PM, review of the staff in-service training records showed that all staff including DSP #1 and DSP #2 received training on Client #1's feeding protocol on 01/16/17. At the time of the survey, observations revealed that the training on Client #1's feeding protocol had not been effective.	W 189		
W 381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, facility nurses failed to ensure medications were maintained under proper conditions of security, for five of five clients residing in the facility (Client #1, 2,3,4,5). Findings included: On 09/20/18 at 6:23 AM, the LPN placed Client #2's medication inside the medication cabinet but failed to lock it. The LPN then went into Client #5's bedroom to administer his Jevity. At 6:42 AM, the LPN returned to the medication office after administering Client #5's Jevity. During this time, Clients #1, 2, 3, 4, 5, and the facility staff were in close proximity to the unsecured	W 381	The LPN received additional training on the facility's Medication Administration Policy and Procedures by DON. RN will monitor weekly for compliance.	10/25/18

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W 381	Continued From page 3 medications. When interviewed on 09/20/18 at 6:45 AM, the LPN acknowledged that the medication cabinet was not locked when he went into Client #5's bedroom to administer his Jevity. At the time of the survey, the facility failed to ensure that all medications were secured by the LPN at all times.	W 381		

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from 09/19/18 through 09/21/18. Three residents were selected from a population of five men 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. DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities QIDP - Qualified Intellectual Disabilities Professional	I 000		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to store poisonous agents in a locked cabinet and/or out of direct reach of each resident, for five of five residents of the facility (Residents #1, 2, 3, 4 and 5). Findings included: During the entrance conference on 09/19/18 at 4:00 PM, the QIDP revealed that Resident #1, 2, 3, 4 and 5 are not competent to give informed consents. According to the QIDP, the resident's functioning level ranges from severe to profound.	I 095	All cleaning supplies will be kept in a locked cabinet and used under close supervision by DSPs. All staff received additional training. QIDP will monitor daily for compliance.	10/29/18

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I 095	Continued From page 1 On 09/21/18, beginning at 3:50 PM, observations revealed cleaning supplies such as Windex, Mr Clean, Lysol and Comet that were labeled poisonous if swallowed. These poisonous agents were stored in an unlocked cabinet in the kitchen and basement. The QIDP who was present at the time of the inspection confirmed that the cleaning supplies were not locked and secured. At the time of the survey, the facility failed to ensure potentially poisonous and/or caustic agent was stored and locked and out of the potential reach of each resident, as required.	I 095		
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 interview and record review, the GHIID failed to ensure that all DSP's had current health certificates that were signed and dated by a physician on file, for two of 13 DSP's reviewed (DSP #3 and 4). Findings included: On 09/20/18, beginning at 2:54 PM, review of the	I 206	DSP #3 and #4 have submitted current health certificates, which were filed in personnel records.	10/25/18

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I 206	Continued From page 2 personnel records for DSPs revealed there was no evidence of a physician's health inventory/certificate for DSP #3 and 4 who provided direct support to five of the five residents residing in the facility. When queried about the missing physician's health inventories on 09/20/18, at approximately 3:45 PM, the QIDP indicated that he would request the aforementioned health certificate. No additional information was made available for review before the survey ended.	I 206		
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, record review and staff interview, the GHID failed to ensure that each resident's mealtime protocol was implemented for one of three residents in the sample (Resident #1). Findings included: On 09/19/18 beginning at 5:20 PM, Resident #1 was observed eating fish, macaroni and cheese, cabbage, carrots and bread at a fast pace. As Resident #1 scooped his food with his teaspoon, DSP #1 used a butter knife to portion the food away from the resident's spoon. At 5:26 PM Resident #1 spilled his water as he drank at a	I 430	DSP #1and #2 received additional training on Client #1's Mealtime Protocol by the QIDP and Nursing Staff. QIDP will monitor for weekly compliance.	10/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0282	A. BUILDING: _____ B. WING _____	09/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI-SERVICES,INC	1701 24TH STREET, NE WASHINGTON, DC 20018

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I 430	Continued From page 3	I 430		

face pace. As the resident drank fast, DSP #1 placed a bowl under the resident's cup to catch the excess water that was spilling.

On 09/20/18 beginning at 6:28 AM, Resident #1 was observed eating cheerios and toast. During this time, DSP #2 touched Resident #1's shoulder and asked him to wait each time he began to eat fast. Further observations showed DSP #2 held a cup of water to the resident's mouth as he drank his water.

Review of Resident #1's mealtime protocol dated 07/24/18 at 9:41 AM, revealed the following:

a. Provide 100% close supervision during all meals.

b. Alternate solids and liquids during the meal.

c. Ensure that his mouth is empty before the next spoonful.

d. Allow one to two teaspoons per swallow.

e. Provide verbal prompts as needed to encourage him to reduce his rate of PO intake.

f. Avoid consecutive swallowing while drinking, for swallow safety and to minimize spillage.

During an interview on 09/20/18, at 8:05 AM, DSP #2 confirmed that Resident #1 has a feeding protocol. DSP #2 stated that he allows the resident time to eat and he holds his cup to prevent spillage.

On 09/21/18, at 3:05 PM, review of the staff in-service training records showed that all staff, including DSP #1 and DSP #2, received training

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	HFD03-0282	A. BUILDING: _____ B. WING _____	09/21/2018

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I 430	Continued From page 4 on Resident #1's feeding protocol on 01/16/17. At the time of the survey, observations revealed that the training on Resident #1's feeding protocol had not been effective.	I 430		