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

PRINTED: 10/18/2018 FORM APPROVED OMB NO. 0938-0391

IND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		09G252	B WING		na	/21/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1701 24TH STREET, NE WASHINGTON, DC 20018	CODE	12112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
E 000	Initial Comments		E 0	00		i
	An emergency prep conducted from 09/	paredness survey was 19/18 through 09/21/18.				
	The findings of the s interviews and revier preparedness progra	survey were based on w of the emergency am.				
5	Note: The below are appear throughout the	e abbreviations that may ne body of this report.				
	EPP - Emergency Pr QIDP - Qualified Inte Professional	llectual Disabilities				
	RA - Risk Assessmen				j	
E 006	CPAP - Continuous F Plan Based on All Ha CFR(s): 483.475(a)(1	Positive Airway Pressure Izards Risk Assessment	E 00			
				The facility's QIDP has o with each person's day p	collaborated	
1	(a) Emergency Plan.	The [facility] must develop		has requested a copy of	their	
t	and maintain an eme	rgency preparedness plan d, and updated at least		Emergency Evacuation	Plan in the	
ē	annually. The plan mi	ust do the following:]		event the person is at th or in the community duri	e day prograr	n
f	acility-based and con	nclude a documented, nmunity-based risk an all-hazards approach.*		emergency/disaster.		11/16/18
c	on and include a docu community-based risk	§483.73(a)(1):] (1) Be based imented, facility-based and assessment, utilizing an				
а	II-hazards approach,	including missing residents.			į.	
a	nd include a docume	.475(a)(1):] (1) Be based on nted, facility-based and				
C	ommunity-based risk	assessment, utilizing an including missing clients.				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution buy 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 program participation.

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

Event ID: 7MUJ11

Facility ID: 09G252

If continuation sheet Page 1 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/18/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 09G252 09/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE COMMUNITY MULTI-SERVICES,INC WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID in PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 006 Continued From page 1 E 006 (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 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.

emergency events.

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

At the time of the survey, the facility failed to coordinate with the day programs to develop a

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		09G252	B. WING		00	104/0040
NAME O	F PROVIDER OR SUPPLIER	19900 - 19900		STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	/21/2018
сомм	UNITY MULTI-SERVICE	S,INC		1701 24TH STREET, NE		
		- 100 - 100		WASHINGTON, DC 20018		
(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 X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 006	Continued From pa	ge 2	E 0	06		
	plan for when client during an emergend (II) On 09/21/18, be	s' are at their day program		The facility's EPP will be revisereviewed to include how to actransportation failure, structured damage, electrical failure, fue	ddress ral el shorta	
	no planning for eme	rgency events that might its were in the community.		or civil disturbances in the ev persons are away from the fa		11/16/18
	QIDP acknowledged provide guidance for tornado warning was were engaged in a c					
	ensure that the EPP	rvey, the facility failed to addressed emergency its were away from the			Terminal of Control of	
	that the facility's RA I hurricanes, thunders the greatest potential added Tornados, biol	ew with the QIDP on at 4:26 PM, the QIDP stated and identified snowstorms, torms and power outage as hazards. The QIDP then nazards, civil disturbance as posing lesser degrees of			The state of the s	
	the facility's EPP (Now "Supply Shortage" wat highest overall risk (at hazards listed were "E "Communications Fait showed the risk of "In and Mass Casualty" was Fire, Flood, Structural Disturbance" was 41%	lure" (at 56%). The RA formation System Failure /as 44%, "Fuel Shortage,				

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

STATEMEI AND PLAN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G252	B. WING	70.00	09/21/2018
COMMU	PROVIDER OR SUPPLIEF JNITY MULTI-SERVIC	ES,INC		STREET ADDRESS, CITY, STATE, ZIP CO 1701 24TH STREET, NE WASHINGTON, DC 20018	DE
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
E 006	Failure" was 37%, and the risk of "Sne 28%.	"Severe Thunderstorm" 33%, ow Fall " and "Blizzard" was	E 006		
	the facility's EPP (Nevidence that the fa how to address train	ning at 10:11 AM, review of November 2017), showed no acility had established plans on asportation failure, structural failure, fuel shortage, or civil			
;	AM, the QIDP acknowledge plans developed to identified risks.	nterview on 09/21/18 at 11:56 owledged that there were no address the aforementioned			it.
E 007	EP Program Patient CFR(s): 483.475(a)	: Population (3)	E 007		i.
	and maintain an em that must be reviewed	n. The [facility] must develop ergency preparedness plan ed, and updated at least nust do the following:]			
	but not limited to, pe services the [facility] an emergency; and o	client population, including, rsons at-risk; the type of has the ability to provide in continuity of operations, sof authority and succession			
•	plans.** *Note: ["Persons at r	isk" does not apply to: ASC			
F	nospice, PACE, HHA FQHC, or ESRD faci This STANDARD is	, CORF, CMCH, RHC, lities.] not met as evidenced by:			
f	Based on interview a ailed to include polic emergency plan to ac	and record review, the facility ies and procedures in the	7		
	retermined to be the	most vulnerable in the risk			8

		E & MEDICAID SERVICES	-,		OMB NO	0. 0938-0391
STATEME AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
24.12		09G252	B. WING		00	/21/2018
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	121/2010
COMM	UNITY MULTI-SERVICE	ES.INC	1	1701 24TH STREET, NE		
		-		WASHINGTON, DC 20018		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 007	7 Continued From pa	age 4	E O	17		1
	•	of five clients residing in the		J1		
	Findings included:			The facility will revise and up EPP to address issues and up	care for	
	QIDP stated that the #5 would be "especemergency due to to Jevity via peg tube, machine. The second	on 09/20/18, at 4:38 PM, the ey had determined that Client ially at risk" during an he client's impaired vision, and the need for CPAP not most "at risk" client was ambulation and the need to		vulnerable clients in the ever emergency.	it or an	11/16/18
	the EPP (November	ning at 10:11 AM, review of 2017), revealed the plan forementioned risks for				0
	Oп 09/21/18, at appl QIDP acknowledged addressed in the EP	roximately 12:30 PM, the I that the client's risk was not P.				
	to address vulnerable emergency.	vey, the facility's EPP failed e clients in the event of an			ij.	
E 022	Policies/Procedures CFR(s): 483.475(b)(4	for Sheltering in Place 4)	E 022	2		
	develop and impleme policies and procedur plan set forth in paragassessment at paragand the communication this section. The polici	redures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be				
Ť	reviewed and updated	d at least annually. At a		1		

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STATEMEN	TOP DESIGNATION	E & MEDICAID SERVICES	-			MB NO	0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	5.73	09G252	B WING				04/00:0
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	09/	21/2018
COMMU	NITY MULTI-SERVICE	ES.INC	1		1 24TH STREET, NE		
				WA	ASHINGTON, DC 20018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 022	Continued From pa	ge 5		100			-x
	address the following		E 0;	22		:: :a	
	address the lonowin	i ā -1				11	
1	(4) A means to shell	ter in place for patients, staff,	:				
	and volunteers who	remain in the [facility]. [(4) or					
	patients staff and	ans to shelter in place for olunteers who remain in the					
	[facility].	rolanteers who remain in the				T.	
	*[For Inpatient Hosp	ices at §418.113(b):] Policies					
	and procedures. (6) The following are	additional requirements for					
-	hospice-operated in	patient care facilities only.					
	The policies and pro	cedures must address the					
Į 1	following:						
	(i) A means to she	elter in place for patients,				- 5	
::	This STANDARD is	who remain in the hospice. not met as evidenced by:				51	
	Based on record rev	riew and interview, the facility					
- 1	alled to develop poli	cies and procedures that					
a	iddress a means of	sheltering in place for					
2	licaster or emergeno	staff in the facility during a					
	lisaster or emergend	cy situations.				4	1
F	indings included:						
	n 00/24/49 hanini						
tl	ne facility's EPP (No	ng at 10:11 AM, review of vember 2017) showed no					1
e	vidence that the faci	lity had developed policies					1
ुa	nd procedures to ad	dress sheltering in place for					- 1
а	dditional clients and	staff.					Î
† o	п 09/21/18, at 12·50	PM, the QIDP said during					
a	n interview that staff	had been trained on what to					
de	should staff and cl	ents need to shelter in					
pl	ace for tornados, bli	zzard, hurricane, etc. The				1	
Q ar	or stated that other b	r persons, such as clients omes, could remain in the				i i	
fa	cility to shelter in ola	ce if/when needed. When					į.
as	ked if there were po	licies and procedures				1	1

		& MEDICAID SERVICES			OMB NO	. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		09G252	B. WING_		00	124/2040
NAME OF	PROVIDER OR SUPPLIER	411	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	/21/2018
COMMU	INITY MULTI-SERVICE	S,INC		1701 24TH STREET, NE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 022	Continued From page outlined in the EPP and staff are in the tafter reviewing the E	for when additional clients facility, the QIDP stated no	E 022	The facility's EPP will be up address sheltering in place emergencies and disasters additional clients and staff.	during for	11/16/18
	that the facility devel in the EPP to addres	rvey, there was no evidence loped policies and procedures as sheltering in place during sasters for additional clients				
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN' AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-03 TE SURVEY
			A. BUILD	ING	co	MPLETED
NAME OF	PROVIDER OR SUPPLIER	09G252	B WING		09	/21/2018
COMMU	NITY MULTI-SERVICE			STREET ADDRESS, CITY, STATE, ZIP CO 1701 24TH STREET, NE WASHINGTON, DC 20018	ODE	
(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	(X5) COMPLETIO DATE
W 000	INITIAL COMMENT	S	W 0	00		
	09/19/18 through 09 selected from a popurarious degrees of ir	vey was conducted from //21/18. Three clients were ulation of five men with ntellectual disabilities. This ed utilizing the focused process.		H.		
	The findings of the sobservations, intervieus administrative record	urvey were based on ews and review of client and ls.	W			
1	Note: The below are appear throughout th	e abbreviations that may e body of this report.				
L (F II N N 189 S	DSP - Direct Support LPN - Licensed Pract QIDP - Qualified Intel Professional PP - Individualized P MAR - Medication Ad STAFF TRAINING PE	tical Nurse Rectual Disabilities rogram Plan ministration Record ROGRAM	W 18			
T ir e	nitial and continuing t	ide each employee with raining that enables the his or her duties effectively			And the same of th	
in cli cc	Based on observation iterview, the facility fa ient's mealtime proto	ot met as evidenced by: n, record review and staff alled to ensure that each acol was implemented three clients in the sample		и У	4.	
Fi	ndings included:					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excluded 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

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

STATEMEN	IT OF DEFICIENCIES	Total Paris Total	1		OWB N	<u>0. 0938-039</u>
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		09G252	B WING_			012412040
	PROVIDER OR SUPPLIER	ES,INC		STREET ADDRESS, CITY, STATE, ZIP CO 1701 24TH STREET, NE WASHINGTON, DC 20018	DDE	9/21/2018
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 189	Continued From pa	age 1	W 18	9		
	observed eating fis cabbage, carrots at Client #1 scooped I DSP #1 used a buttaway from the client #1 spilled his water the client drank, DS	ning at 5:20 PM, Client #1 was h, macaroni and cheese, and bread at a fast pace. As his food with his teaspoon, ter knife to portion the food at's spoon. At 5:26 PM Client as he drank at a fast pace. As SP #1 placed a bowl under the the excess water that was		DSP #1 and #2 received a training on Client's #1 Mea Protocol by the QIDP and Staff. QIDP will monitor we compliance.	altime Nursing	10/29/18
	observed eating che time, DSP #2 touche asked him to wait ea Further observations	eerios and toast. During this eerios and toast. During this ed Client #1's shoulder and each time he began to eat fast. Is showed DSP #2 held a cup term of the cup term of th				
	Review of Client #1': 07/24/18 at 9:41 AM	s mealtime protocol dated , revealed the following:		1		
	a. Provide 100% clos neals.	se supervision during all				
t to	. Alternate solids ar	nd liquids during the meal.				
s	. Ensure that his mo poonful.	outh is empty before the next				
d	. Allow one to two te	easpoons per swallow.				
e e	. Provide verbal pro ncourage him to red	mpts as needed to luce his rate of PO intake.				
f.	Avoid consecutive s wallow safety and to	swallowing while drinking, for minimize spillage.				

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

OLIVILATO I ON WILD	CATILL OF IN	EDICAID SERVICES			OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA	ATE SURVEY IMPLETED
		09G252	B. WING		00	9/21/2018
NAME OF PROVIDER OR SUF COMMUNITY MULTI-SE	RVICES,ING			STREET ADDRESS, CITY, STATE, ZIP 1701 24TH STREET, NE WASHINGTON, DC 20018	CODE	7/2018
PREFIX (EACH DEFI	ICIENCY MUST	NT OF DEFICIENCIES F BE PRECEDED BY FULL INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
#2 confirmed protocol. DSP time to eat and spillage. On 09/21/18, a in-service train including DSP on Client #1's At the time of the that the training had not been element with the training had not been element. The facility must conditions of set of the facility must condition of the faci	erview on 0: that Client #2 stated d he holds at 3:05 PM ning record #1 and DS feeding pro the survey, g on Client effective. AGE AND F 50(I)(1) st store dru ecurity. RD is not in ervation and ensure me lier proper of lients resid ad: 6:23 AM, tt inside the The LPN th administe turned to th ing Client # s #1, 2, 3, 4	2/20/18, at 8:05 AM, DSP #1 has a feeding that he allows the client his cup to prevent review of the staff is showed that all staff is showed that all staff is preceived training stocol on 01/16/17. observations revealed #1's feeding protocol ECORDKEEPING ags under proper the as evidenced by: d interview, facility edications were conditions of security, ing in the facility (Client the LPN placed Client medication cabinet but then went into Client r his Jevity. At 6:42 the medication office the staff the s	W 18		on Administra by DON. RN	ation 10/25/18

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

		A MILDICAID SERVICES				OMB NO.	0938-039
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONS		(X3) DATI	E SURVEY IPLETED
		09G252	B. WING				
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	1 09/2	21/2018
COMMU	INITY MULTI-SERVICE	S INC	1		H STREET, NE		
				WASHIN	IGTON, DC 20018		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CF	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 381	Continued From pagmedications.	ge 3	W 38	31			
	When interviewed o	n 09/20/18 at 6:45 AM, the	1				
	LPN acknowledged	that the medication cabinet				1	
	was not locked when bedroom to adminis	n he went into Client #5's ter his Jevity.					
	At the time of the su	rvey, the facility failed to	V				
	ensure that all medic LPN at all times.	cations were secured by the				9	
	LPN at all times.		X.				
			1				
				1			
						1	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG:		E SURVEY
		A. BOILDIN			
an and a second	HFD03-0282	B. WING_		09/	21/2018
AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY	, STATE, ZIP CODE		112/11
OMMUNITY MULTI-SERVICE		TH STREET			
(X4) ID SUMMARY STA	WASHIN ATEMENT OF DEFICIENCIES	GTON, DC			
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE
1 000 INITIAL COMMEN	rs	1000		1	- L
through 09/21/18. from a population of degrees of intellection. The findings of the observations, intervand administrative of the support of	survey were based on iews and review of resident ecords. e abbreviations that may he body of this report. rt Professional e for Individuals with es				
a locked cabinet and	PING ustic agent shall be stored in shall be out of direct reach	1095	All cleaning supplies will be locked cabinet and used un supervision by DSPs. All sta	der close	ed.
of each resident.			additional training. QIDP will daily for compliance.	l monitor	10/29/1
failed to store poison cabinet and/or out of	n and interview, the GHIID ous agents in a locked direct reach of each re residents of the facility			10 - Haran	
Findings included:	1				
4:00 PM, the QIDP re 3, 4 and 5 are not cor consents. According i	conference on 09/19/18 at evealed that Resident #1, 2, impetent to give informed to the QIDP, the resident's es from severe to profound.				

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program 1)inecto

1-14/18

If continuation sheet 1 of 5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY		
	IDENTIFICATION NOWBER.		A. BUILDIN	NG:	COMPLETED	
		HEDO2 0202	B. WING		450000	
		HFD03-0282	D. VVIIVE _	**************************************	09/	21/2018
NAME OF	PROVIDER OR SUPPLIER			Y, STATE, ZIP CODE		
COMMU	NITY MULTI-SERVICE		H STREET			
(Y4) ID	SUMMADVICTA	TEMENT OF DEFICIENCIES	GTON, DC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5 COMPL DAT
1095	Continued From page	ge 1	1095			
*	revealed cleaning statements. Clean, Lysol and Copoisonous if swallow were stored in an unand basement. The QIDP who was inspection confirmed were not locked and At the time of the surensure potentially po	vey, the facility failed to isonous and/or caustic agent				The second secon
l 206; ;	reach of each reside 3509.6 PERSONNEL Each employee, prior annually thereafter, s	POLICIES	1206	DSP #3 and #4 have subr current health certificates, filed in personnel records.	which were	e 10/25/
F	performed and that the	ne employee 's health status er to perform the required				
fa c p	ailed to ensure that a ertificates that were :	et as evidenced by: ad record review, the GHIID all DSP's had current health signed and dated by a vo of 13 DSP's reviewed			4	
_j F	indings included:				1	
10	n 09/20/18, beginnin		1			

neam	Regulation & Licensing	ng Administration			FORM APPROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HFD03-0282	B. WING		09/21/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	/, STATE, ZIP CODE	03/21/2010		
COMMU	NITY MULTI-SERVICE	S,INC 1701 24T	H STREET STON, DC	, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) BE COMPLET ATE DATE	
1206	Continued From page	ge 2	1206			
1	no evidence of a phinventory/certificate provided direct suppresiding in the facility. When queried about health inventories or 3:45 PM, the QIDP is request the aforeme additional information review before the sur	for DSP #3 and 4 who cort to five of the five residents y. the missing physician's no 09/20/18, at approximately ndicated that he would not one was made available for	1430	DSD #1 and #2 received addition		
E E III CO	The habilitation and to GHMRP shall include be limited to, the followard for the fol	raining of residents by the when appropriate, but not wing areas: g (including table manners, ment, and use of		DSP #1and #2 received addition training on Client #1's Mealtime Protocol by the QIDP and Nursin Staff. QIDP will monitor for week compliance.	na	

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PRINTED: 10/18/2018 FORM APPROVED

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: B WING HFD03-0282 09/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE COMMUNITY MULTI-SERVICES,INC WASHINGTON, DC 20018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DATE DEFICIENCY) 1430 Continued From page 3 1430 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. 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 Health Regulation & Licensing Administration

	NT OF DEFICIENCIES		L (UA) I II II MITTE	- 0.010001100101	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HFD03-0282	B. WING			
AVAILE OF THE VIEW			DRESS, CITY, STATE, ZIP CODE		09/21/2018	
		4704.04				
COMMU	NITY MULTI-SERVICE		TH STREET, N IGTON, DC 20			
(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 COMPLETE	
1 430	Continued From page 4		1430			
	on Resident #1's fee	eding 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.		All and		1 0 0 0	
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