019 ΈD 91

| STATEMENT OF DEFICIENCIES | RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (V2) MU TIC: C | CONSTRUCTION | OMB NO. 093 |
|--|---|---------------------|---|--------------------------|
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | CONSTRUCTION | (X3) DATE SUF COMPLET |
| | 09G255 | B. WING | | 05/16/20 |
| NAME OF PROVIDER OR SUPPLIE | CES | 1 | REET ADDRESS, CITY, STATE, ZIP COASHINGTON, DC 20017 | ODE CONTRACT |
| PREFIX (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE GOM |
| W 000 INITIAL COMMEN | NTS | W 000 | | |
| o5/15/19 through of selected from a polyarious degrees of survey was conducted fundamental survey. The findings of the observations, interpretative recommendation of the survey findings was in substantial of requirements of 42 Requirements for least the selected from the survey findings was in substantial of requirements of 42 Requirements for least the selected from th | e survey were based on views and review of client and ords. s determined that the facility compliance with the CFR 483, Subpart I, intermediate Care Facilities. | | | |
| No deficiencies we | re cited. | | pel . | * |
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| | | | | |

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

LABORATORY DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

| | NT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | HFD03-2888 | | B. WING | 05/16/2019 | | | |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | | | |
| COMMU | NITY MULTI-SERVICE | S WASHIN | GTON, DC 20 | 017 | | | |
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| 1 000 | INITIAL COMMENT | -S | 1 000 | | | | |
| | to 05/16/19. A samp selected from four v The findings of the | survey were based on iews and review of resident | a a a | | | | |
| | The following abbre throughout the repo | viations will appear rt: | | | | | |
| | DSP - Direct Suppor GHIID - Group Hom Intellectual Disabilitie QA - Quality Assurar QIDP - Qualified Inte Professional RN - Registered Nur | e for Individuals with es nce Officer ellectual Disabilities | | | <u>#</u> | | |
| 1 206 | 3509.6 PERSONNE | L POLICIES | 1 206 | | | | |
| ; ; ! | annually thereafter, s certification that a he performed and that t | r to employment and shall provide a physician 's alth inventory has been he employee 's health status er to perform the required | | | | | |
| r e fo | eview, the GHIID fail employee had a curre or three of 15 DSP p | n, interview and record ed to ensure that each ent health certificate on file, ersonnel files reviewed the registered nurse (RN), | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER REPRESENTATIVE'S SIGNATURE

(X8) DATE

(X8)

PRINTED: 05/28/2019

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| HFD03-2888 | B. WING | | 05/16/201 |
| STREET A | DDRESS, CIT | Y, STATE ZIP CODE | 1 03/10/201 |
| ES | | | |
| ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID | PROVIDER'S PLAN OF CORRECTION SHOUL | D BE COMP |
| ige 1 | 1 206 | | |
| | | | |
| William State of the State of t | | | |
| aled the following: ertificate was dated 03/23/18; ot show evidence of a health ertified by a physician. (There mentation showing that she result when tested for 0/18); | | DSP#2 and #8 have obtained health certificates. | their 5/17/′ |
| ertificate was dated pared with the facility's quality A) and the QIDP at 10:57 | | on 1/11/19 and was filed on 5/QIDP/QA will monitor personne quarterly to ensure current hea | 17/19. el records |
| AM, the QIDP and the QA ad a doctor's appointment of day (05/17/19). When been on the schedule in and had worked with the d'yes." At 11:07 AM, the 2 #13 recently had received exam; however, she had not difficate from her physician. Sked to return to the doctor ry clearance. No additional DSP# 8 was shared before | | | <i>3.117</i> 1 |
| | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) age 1 :12 AM, DSP #2 greeted the lity door. Moments later, DSP asisting Resident #2 with At 4:10 PM, DSP #13 was th DSP #3, who had worked at was about to leave. At 4:30 asserved preparing dinner in versing with the QIDP. All asserved interacting with the ir respective shifts on that day and the following: artificate was dated 03/23/18; but show evidence of a health certified by a physician. (There mentation showing that she esult when tested for 0/18); ertificate was dated ared with the facility's quality A) and the QIDP and the QA and a doctor's appointment and had worked with the dat and had worked with the data and | WASHINGTON, DC ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) TAG 12 AM, DSP #2 greeted the lity door. Moments later, DSP sisisting Resident #2 with At 4:10 PM, DSP #13 was th DSP #3, who had worked did was about to leave. At 4:30 pserved preparing dinner in versing with the QIDP. All pserved interacting with the ir respective shifts on that day ing at 9:15 AM, review of the aled the following: prificate was dated 03/23/18; pot show evidence of a health pertified by a physician. (There mentation showing that she result when tested for 0/18); ertificate was dated ared with the facility's quality A) and the QIDP and the QA and a doctor's appointment at day (05/17/19). When been on the schedule in and had worked with the di "yes." At 11:07 AM, the difficate from her physician. ked to return to the doctor ry clearance. No additional DSP# 8 was shared before | WASHINGTON, DC 20017 INTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CACH OR THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CHANCE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CACH OR THE APPRO DEFICIENCY) ID PROVIDENT ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDER'S PLAN OF CACH OR THE APPRO DEFICIENCY) ID PROVIDENT ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDENT ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDENT ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDENCE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) ID PROVIDENCE ACTION SHOULD CROSS-REFICENCE TO THE APPRO |

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| | | HFD03-2888 | B. WING_ | | 05/16/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CIT | Y, STATE, ZIP CODE | |
| COMMU | INITY MULTI-SERVICE | S | STON, DC | 20047 | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | NA . |
| PRÉFIX TAG | | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETE |
| 1 206 | Continued From page | ge 2 | 1 206 | | - |
| | the survey ended. | | | | |
| | 2. On 05/15/19 hegi | nning at 2:39 PM, the RN was | r | | |
| | interviewed in the fa | cility's nursing office on the | : | | 4 |
| | top floor. She was o | bserved engaged with staff the days of the survey. | | | 181 |
| | | • | | | * |
| | On 05/16/19 at 10:4 | B AM, review of the personnel e RN revealed a health | | | |
| | certificate 03/16/18. | e niv revealed a nealth | | 1 | |
| | On 05/16/10 of 10:59 | O AM the eference where t | | | |
| | finding was shared w | AM, the aforementioned vith the QA and QIDP. They | | 1 | |
| | confirmed that the R | N had worked with the | | | |
| 126 | residents during the - 05/16/19. They state | two-month period of 03/16/19 ed they would check with the | | | |
| | agency's human reso | ources officer. No additional sed before the survey ended. | | | |
| | 3. On 05/15/19 at 9:3 | 7 AM, the Fitness Instructor | | | 3 |
| | was observed workin | g with Resident #1 | | The fitness instructor will obtain health partificate OLDB/CA will | |
| | Beginning at 10:08 A | exercises in the basement. M, the Fitness Instructor was | | health certificate. QIDP/QA will quarterly to ensure all credenti | |
| | observed working wit | h Resident #2 performing | | remain current. | 6/30/19 |
| | physical exercises. | | | | į |
| | On 05/16/19 at 10:45 | AM, review of the personnel | | | |
| | file maintained for the no evidence of a heal | Fitness Instructor revealed | | | 2 |
| 9 | certified by a physicia | n inventory that was n. | | | τ. |
| | On 05/16/10 at 14:00 | AM the OA state of the state | | | |
| 1 | would ask the agency | AM, the QA stated that she should be | | | 10 |
| ā | about a health certific | ate.She also agreed to ask 📱 | | | |
| ١ | whether the written co and the fitness compa | intract between the GHIID in the submit | | | |
| á | a health certificate for | any fitness instructor sent | | | |
| t | o work with the reside | ents of this facility. No | | | 9 |
| 5 | survey ended. | was shared before the | | | |

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| STATEME AND PLA | ENT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING: | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | HFD03-2888 | B. WING | | 05/16/2019 |
| NAME OF | PROVIDER OR SUPPLIER | STREET | DDRESS, CITY, S | STATE, ZIP CODE | |
| COMMU | INITY MULTI-SERVICE | S WASHIN | IGTON, DC 20 | 017 | |
| (X4) ID PREFIX TAG | EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE COMPLETE JE APPROPRIATE DATE |
| 1 206 | Continued From page | ge 3 | 1 206 | | |
| | show evidence that system that ensures | rvey, the facility failed to they had implemented a that every employee working otained an annual health | | | |
| 1229 | 3510.5(f) STAFF TR | AINING | 1 229 | | |
| | Each training progra limited to, the followi | m shall include, but not be ng: | | | |
| | residents to be serve to, behavior manage | elated to the GHMRP and the ed including, but not limited ment, sexuality, nutrition, munications, and assistive | | | |
| | review, the GHIID fail who was assigned to maintained current co | n, interview and record led to ensure that each DSP provide one-to-one supports ertification in The Mandt one-to-one staff (DSPs #1, | | | |
| | Findings included: | | | | 2 |
| f s | four of the clients rece supports during the da | AM, the QIDP stated that all eived one-to-one staffing ay. Observations during the ents #1, 2, 3 and 4 had pports. | | | ,ª |
| р - М | personnel files revealed DSP #4 and 12's files Mandt training; | g at 9:15 AM, review of the ed the following: s did not show evidence of hing certificate showed it | | | |

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| | Health Regulation & Licensi | ng Administration | | | I OKWI AFFROVED |
|---|--|--|--------------------------|---|-------------------------------|
| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G: | (X3) DATE SURVEY COMPLETED |
| | | HFD03-2888 | B. WING_ | | 05/16/2019 |
| | NAME OF PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY | , STATE, ZIP CODE | 03/10/2013 |
| | COMMUNITY MULTI-SERVICE | | • | | |
| _ | and the second s | WASHING | GTON, DC | 20017 | |
| | PREFIX (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 CROSS-REFERENCED TO THE APPROPRICIENCY) | D BE COMPLETE |
| | 1229 Continued From pa | ge 4 | 1229 | | 110-1 |
| | expired on 01/31/18 - DSP #2's Mandt tr 04/30/16; - DSP #3's Mandt tr 11/30/17; - DSP #7's Mandt tr 05/31/17; - DSP #9's Mandt tr 02/28/19; - DSPs #10 and 13's expired on 06/30/18 - DSP #14's Mandt tr 06/30/17. The one-to-one job of training as a qualificate. The findings were shassurance officer (Q. AM. At 11:00 AM, the were cross-trained to supports for any of the that Resident #4 was She further stated the have current Mandt to one-to-ones." The Q/ follow-up with the hur additional information before the survey end At the time of the survey system that ensures to providing one-to-one: | aining certificate expired on descriptions listed Mandt ation for that position. It is a control of the contro | 1225 | DSP #2, #3, #7, #9, #10 and a receive MANDT Training and their certificates of completion QIDP/QA will monitor annually ensure current MANDT Training | receive n. v to |
| | ± | | | | |

PRINTED: 05/28/2019 FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO. 0938-039 |
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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 0.00 | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 09G255 | B WING_ | | 05/16/2019 |
| NAME OF | PROVIDER OR SUPPLIER | <u></u> | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 03/10/2019 |
| COMMU | NITY MULTI-SERVICE | :S | | WASHINGTON, DC 20017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE COMPLETION |
| E 000 | Initial Comments | | E 00 | 0 | |
| | An emergency prep conducted from 05/ | paredness survey was 15/19 through 05/16/19. | | | |
| | The findings of the sinterviews and revie preparedness progr | survey were based on w of the emergency am. | | | |
| | | e abbreviations that may he body of this report. | | | |
| | QIDP - Qualified Inte Professional | n reparedness Program ellectual Disabilities | | | |
| E 006 | QA - Quality Assurar Plan Based on All Ha CFR(s): 483.475(a)(| azards Risk Assessment | E 006 | The facility's Program Directory will review and revise its risk | or/ QIDP |
| | (a) Emergency Plan and maintain an eme that must be reviewe | . The [facility] must develop ergency preparedness pland, and updated at least ust do the following:] | | to include potential hazards a leaks specific to its geograph Staff will receive training on that and Procedures for Handling Responding to hazardous man | such as gas nic location. the Policy and/or aterials |
| 1 | facility-based and co | include a documented, mmunity-based risk an all-hazards approach.* | | by the QIDP. | 6/30/19 |
| (| on and include a doc community-based ris | §483.73(a)(1):] (1) Be based umented, facility-based and k assessment, utilizing an , including missing residents. | | | |
| 6 | and include a documo community-based risl | 3.475(a)(1):] (1) Be based on ented, facility-based and cassessment, utilizing an including missing clients. | | | |

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.

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

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| | | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | | FOR | M APPROVE |
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| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | | CONSTRUCTION | (X3) D/ | O. 0938-039 ATE SURVEY OMPLETED |
| | | 09G255 | B. WING | | | 1 0 | 5/16/2019 |
| NAME OF | PROVIDER OR SUPPLIER | 11-2-3- | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | | 3/10/2010 |
| COWWR | JNITY MULTI-SERVICE | ES . | | WA | ASHINGTON, DC 20017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X. | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | LD BE | (X5) COMPLETION DATE |
| E 006 | Continued From pa | ge 1 | E 00 |)6 | | | ī |
| | (2) Include strategic events identified by | es for addressing emergency the risk assessment. | | | | | |
| | strategies for addressidentified by the risk management of the failures, natural disast that would affect the care. This STANDARD is Based on observation to identification, for four of facility (Clients #1, 2, 2) | ify potential hazards (Gas e facility's geographic our clients residing in the | | | | | |
| 1 | Findings included. | | | | | | |
| Í | facility's location show was located directly a | AM, observation of the wed that a shell gas station across from the facility undred feet away or less. | | | | | |
| 9 | during an interview th | ng at 3:02 PM, the QIDP said nat a gas leak, power outage, s and snowstorm posed a ity's location. | | | | | 2 |
| C | On 05/16/19 beginnin | ng at 10:28 PM, review of the | | | | | |

facility's risk assessment verified the QIDP's interview that snowstorms, severe thunderstorms and power outage were assessed to be a high potential hazards for this facility's location.

At 1:25 PM, a follow-up interview was conducted

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| STATEMEN | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTI A BUILDIN | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 09G255 | B. WING | The state of the s | 05/16/2019 |
| NAME OF | F PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/10/2013 |
| COMM | UNITY MULTI-SERVICE | :S | | WASHINGTON, DC 20017 | |
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| | with the facility's QII assessments. When not added as part of the QIDP and QA st discussion about ad assessment when cothat she would revise. At the time of the sudevelop an all-hazar community-based rispotential hazards splocation. Local, State, Tribal CCFR(s): 483.475(a)([(a) Emergency Plan and maintain an emethat must be reviewed annually. The plan must be reviewed annually be reviewed annually be reviewed annual | DP and QA regarding the risk on asked why gas leak was of their risk assessment, both tated that the team had a diding gas leak to the risk cited last year. The QA said sit the concern with the team. Invey, the facility failed to refacility-based and sk assessment to identify the pecific to their geographic. Collaboration Process (4) In. The [facility] must develop ergency preparedness planted, and updated at least must do the following:] Is for cooperation and cal, tribal, regional, State, and preparedness officials' efforts ated response during a cy situation, including a facility's efforts to contact then applicable, of its porative and cooperative. I only at §494.62(a)(4)]: (4) is cooperation and al, tribal, regional, State, and preparedness officials' efforts ated response during a cooperation and al, tribal, regional, State, and preparedness officials' efforts ated response during a | | | in the Procedure ity to leral nd rgency be |

documentation of the dialysis facility's efforts to

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| | | H AND HUMAN SERVICES E & MEDICAID SERVICES | | F | ORM APPROVE 3 NO. 0938-039 |
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| | OF DEFICIENCIES FCORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | PPLIER/CLIA (X2) MULTIPLE CONSTRUCTION | | 3) DATE SURVEY COMPLETED |
| | | 09G255 | B WING | | 05/16/2019 |
| NAME OF PE | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 00/10/2018 |
| | ITY MULTI-SERVIC | | | WASHINGTON, DC 20017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |

E 009 Continued From page 3

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 05/15/19, beginning at 3:02 PM, the QIDP said during an interview that she had not reached out to the local, regional, state and federal EP officials to ensure an integrated response during a disaster or an emergency situation. The QIDP stated that she was not certain if the facility's administrators reached out to the local, regional, state and federal EP officials to ensure an integrated response during a disaster or an emergency situation. The QIDP stated that she would follow up with her supervisor.

On 05/16/19, at 12:00 PM, review of the facility's EPP updated on 02/27/19 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 1:32 PM, the QIDP confirmed that the team had not reached out to

E 009

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO. 0938-0391 |
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| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 09G255 | B. WING | The state of the s | 05/16/2019 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD | E |
| COMMU | NITY MULTI-SERVICE | s | | WASHINGTON, DC 20017 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | OULD BE COMPLÉTION |
| E 009 | Continued From page | ge 4 | E 0 | 09 | |
| | | and federal officials | _ • | | |
| | that the facility deve that ensured cooper local, regional, state efforts to ensure an disaster and/or eme Policies/Procedures-CFR(s): 483.475(b)((b) Policies and prodevelop and implempolicies and proceduplan set forth in para assessment at paragand the communicat this section. The policies and update | cedures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of cies and procedures must be d at least annually. At a s and procedures must | E 02 | The Program Director will of policy and procedure for the volunteers during a disaste emergency. The facility will Volunteer Emergency Conf | e use of r or utilize a |
| ; 1 1 | volunteers in an eme staffing strategies, in- for integration of Stat | as noted above] The use of rgency or other emergency cluding the process and role e and Federally designated nals to address surge needs | | 9 | <u>v</u> |
| ; 6 5 | procedures. (6) The usemergency and other | 3.748(b):] Policies and use of volunteers in an emergency staffing surge needs during an | | | |

*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | : 05/28/201 APPROVE |
|--------------------------|---|---|----------------------|-----|---|----------|------------------------------------|
| STATEME | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DAT | . 0938-039 TE SURVEY MPLETED |
| | | 09G255 | B, WING | | | 05 | 16/2019 |
| NAME C | F PROVIDER OR SUPPLIER | MILES | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | 1 03/ | 10/2019 |
| COMM | UNITY MULTI-SERVICE | S | | WA | SHINGTON, DC 20017 | | |
| (X4) IC PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | IO PREFIX TAG | ĸ | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| E 02 | 4 Continued From page | ne 5 | ΕO | 24 | | | |
| | an emergency and | other emergency staffing | EU | 24 | | | |
| | strategies, including | the process and role for and Federally designated | | | | | |
| | health care profess | ionals to address surge | | | | | |
| | needs during an em This STANDARD is | ergency. not met as evidenced by: | | | | | |
| | Based on record re | view and interview, the facility | | | | | |
| | address the use of v | icies and procedures that olunteers during an | | | | | |
| | emergency, for four facility (Clients #1, 2 | of four clients residing in the | | | | | |
| | | , 5 and 4). | | | | 1 | |
| | Findings included: | | | | | ĵ | |
| | On 05/15/19 beginning | ng at 3:02 PM, the QIDP said hat the facility would not use | | | | Ĩ | |
| | volunteers during an | emergency situation. | | | | 1 | |
| | On 05/16/19 beginning | ng at 10:28 AM, review of the | | | | | |
| | facility's EP, updated | on 02/27/19 showed no | | | | | |
| | developed to address | s and procedures had been show and if the facility would | | | | | |
| | use volunteers during | emergencies. | | | | | |
| | At 1:45 PM, the QIDF | and QA looked through the | | | | | |
| | and procedure related | ed that there was no policy I to the use of volunteers | | | | | |
| | during emergency sit | uations. | | | | - 2 | |
| | At the time of the sun | vey, there was no evidence | | | | | |
| | that the facility's EP a volunteers during eme | ddressed the use of | | | | | ĺ |
| E 037 | EP Training Program | | E 03 | 7 | | 7 | |
| | CFR(s): 483.475(d)(1 |) | | | | | |

(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:

ΞD

6/7/19

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | FOR | M APPROVE D. 0938-039 |
|--|---------------------------------|---|--------------------------|--|--------------------------------|---------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DA | ATE SURVEY OMPLETED |
| | -2 | 09G255 | B. WING_ | | 0.4 | 5/16/2019 |
| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP | | 10/2019 |
| COMMUN | ITY MULTI-SERVIC | ES | 1 | | | |
| | | | | WASHINGTON, DC 20017 | | |
| (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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETIO DATE |

E 037 Continued From page 6

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
- (ii) Provide emergency preparedness training at least annually.
- (iii) Maintain documentation of the training.
- (iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
- (ii) Provide emergency preparedness training at least annually.
- (iii) Maintain documentation of the training.
- (iv) Demonstrate staff knowledge of emergency procedures.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:

- (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
- (ii) Demonstrate staff knowledge of emergency procedures.
- (iii) Provide emergency preparedness training at least annually.
- (iv) Periodically review and rehearse its emergency preparedness plan with hospice

E 037 DSP#4 and #15 received training on the EPP by the QIDP. QIDP will train all employees annually and review EPP Training Records quarterly to ensure training is completed for new and senior employees.

PRINTED: 05/28/2019

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | M APPROVEE D. 0938-0391 |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
| İ | | 09G255 | B. WING | | | 0,4 | ://6/2040 |
| NAME OF PROVIDER OR SUPPLIER | | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | 1 00 | 5/16/2019 |
| COMMUNITY MULTI-SERVICES | | | | WAS | SHINGTON, DC 20017 | | |
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| E 037 | Continued From pa | ge 7 | E 037 | 1 | | | |
| | | ig nonemployee staff), with | ⊏ 037 | | | | |
| | special emphasis pl | aced on carrying out the ary to protect patients and | | | | | |
| | others. | ary to protect patients and | | | | | |
| | | | | | | | |
| | "[For PRIFs at §44" | 1.184(d):] (1) Training | | | | | |
| | (i) Initial training in a | must do all of the following: | | | | | |
| | nolicies and procedu | mergency preparedness ares to all new and existing | | | | | |
| | staff individuals pro- | viding services under | | | | |) |
| | | plunteers, consistent with their | | | | | |
| | expected roles. | wanted of some other with their | | | | | |
| | (ii) After initial trainin | g, provide emergency | | | | | |
| | preparedness training | g at least annually. | I | | | | |
| | | ff knowledge of emergency | | | | | |
| | procedures. | | | | | | |
| | (IV) Maintain docume | entation of all emergency | | | | |) |
| | preparedness trainin | g. | | | | | |
| | *IFor PACE at 8460 I | 84(d):] (1) The PACE | | | | | |
| | organization must do | all of the following: | | | | | |
| | (i) Initial training in er | nergency preparedness | | | | | |
| | policies and procedu | res to all new and existing | | | | | |
| | staff, individuals prov | iding on-site services under | | | | | 1 |
| | arrangement, contrac | ctors, participants, and | | | | | 1 |
| | volunteers, consisten | t with their expected roles. | | | | | |
| | 50000000000 | cy preparedness training at | | | | | |
| | least annually. (iii) Domanatrata ataé | film made described | | | | | |
| • | (III) Demonstrate star | f knowledge of emergency informing participants of | | | | | 1 |
| 1 | what to do where to | go, and whom to contact in | | | | | |
| , | case of an emergenc | v | | | | | 1 |
| (| iv) Maintain docume | ntation of all training. | | | | | |
| (| CORF must do all of t i) Provide initial traini | | | | | | |

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | C | MB NO. 0938-03 | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | (X3) DATE SURVEY COMPLETED | | | | |
| | | 09G255 | B. WING _ | | | 05/16/2019 | |
| NAME OF | | | STRE | EET ADDRESS, CITY, STATE, ZIP CODE | 03/10/2019 | _ | |
| сомми | NITY MULTI-SERVICE | S | | WAS | SHINGTON, DC 20017 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | DE COMPLÉTIC | מכ |
| | under arrangement, with their expected in (ii) Provide emerger least annually. (iii) Maintain docume (iv) Demonstrate state procedures. All new and assigned specifithe CORF's emerge their first workday. Tinclude instruction in alarm systems and sequipment. *[For CAHs at §485.6] The CAH must do all repolicies and procedure providing and extinguished where necessary personnel, and guest cooperation with firefauthorities, to all new individuals providing and volunteers, considuest annually. (iii) Maintain document procedures. [For CMHCs at §485.6] The CMHCs at §485.6] Th | dividuals providing services and volunteers, consistent roles. Incy preparedness training at entation of the training. If knowledge of emergency personnel must be oriented in responsibilities regarding may plan within 2 weeks of the training program must the location and use of signals and firefighting. S25(d):] (1) Training program, of the following: mergency preparedness res, including prompt hishing of fires, protection, or, evacuation of patients, is, fire prevention, and ighting and disaster | E 03 | 7 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | | |

under arrangement, and volunteers, consistent

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| NAME OF PROVIDER OR SUPPLIER 09G255 B WING STREET ADDRESS, CITY, STATE, ZIP CODE | |
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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 09G255 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | CLIDVEY |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | PLETED |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | 6/2019 |
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| COMMUNITY MULTI-SERVICES WASHINGTON, DC 20017 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to show evidence that it trained all staff on initial emergency preparedness training, for two of fifteen newly hired staff employed by the facility (DSPs #4 and 15). Findings included: On 05/15/19, at 2:16 PM, DSP #15 was asked about the facility's EPP and tracking system during an emergency. DSP #15 said that she had not received initial training on the facility's EPP and that she just started working at the facility in February 2019. DSP #15 stated that she was the in-home day program teacher. When asked, DSP #15 stated that she works in the facility five days a week from 9:00 AM to 3:00 PM. At 2:44 PM, DSP #4 was interviewed regarding the facility's tracking system during an emergency. DSP #4 said that she was unaware of the facility's tracking system. When asked, DSP #4 stated that she has not had initial training on the facility's EP since she started working at the facility in March 2019. At 3:07 PM, the QIDP was asked about initial EP | |

training for DSP #4 and DSP #15. The QIDP confirmed that DSP #4 and DSP #15 had not received initial training on the facility's EP. The QIDP said that a total of four DSPs needed to be

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| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | RM APPROVE |
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| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | LE CONSTRUCTION | (X3) I | O. 0938-039 DATÉ SURVEY COMPLETED |
| | | 09G255 | B. WING | _ | | ١, | 05/16/2019 |
| NAME OF | PROVIDER OR SUPPLIER | · | 1 | s | STREET ADDRESS, CITY, STATE, ZIP COD | E ' | 70/10/2013 |
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| E 037 | Continued From patrained on the EP. | ge 10 | € 03 | 37 | | | |
| | EP in-service training | ng at 10:28 AM, review of the g documents showed no cility had trained DSP #4 and P. | | | | | |
| 3 | At 1:50 PM, the QID four newly hired DSI | P said that training for the Ps is scheduled for 06/03/19. | | | | | |
| | | rvey, there was no ce that newly hired staff ng on the facility's EPP. | | | | | |
| | | | | | | | 2 |
| | | | | | | | |
| | | | | | | | |
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GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

Mailing Address 899 North Capitol St., NE Washington DC 20002 2nd Floor 202-724-8800

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| Name of Earlist | | | | | | |
|------------------------|--|--|------------|----------------------------|---------------------|-------------------|
| Name of racility. | | Street Address, City, State, ZIP Code: | state, ZIF | P Code: | Survey Date: | |
| Comm | Community Multi-Services, Inc. | | | | 5/15/18 | 5/15/19 - 5/16/19 |
| | | Wash | hington, | Washington, DC 20018 | Follow-up Dates(s): | tes(s): |
| Regulation Citation | Statement of De | Deficiencies | Ref. | Plan of Correction | lo | Completion |
| 000 | A licensure survey was conducted from 05/15/19 through 05/16/19. A sample of two residents was selected from a population of four women. | ucted from 05/15/19 of two residents was four women. | | | | Date |
| | The findings of the survey were based on observations, interviews and review of resident and administrative records. | were based on nd review of resident and | | | | |
| | Note: The following abbreviations will appear throughout the report: | tions will appear | | | | |
| | GHIID – Group Home for Individuals with Intellectual Disabilities QA – Quality Assurance Officer QIDP - Qualified Intellectual Disabilities Professional | viduals with er Jisabilities | | | | |
| | | | | | | |
| Name of | Name of Inspector Date I | Jab/19 Date Issued | .] | Facility Director/Designee | se felu | 6/11/19 Date/ |

GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR Rev. 9/02

DEPARTMENT OF HEALTH HEALTH REGULATION & LICENSING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

476

Background Check Requirement

Each facility...shall cause each prospective employee or contract worker who will have, or foreseeably may have direct patient, resident or client access, to undergo a criminal background check that shall reveal the criminal history, if any, in the District of Columbia and the fifty (50) states. Finger printing or live scan shall be performed in the District of Columbia utilizing the Metropolitan Police department (MPD) or a private agency. The criminal background check shall be performed, following finger printing or live scan, by the MPD and Federal Bureau of Investigation (FBI) in an FBI-approved environment. The results of the criminal background checks shall be forwarded to the Department of Health.

Based on review of personnel records and interview with management staff, there was no evidence that the facility obtained a finger print or live scan, for one of 19 employee files reviewed (a fitness instructor).

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

CRFMR Rev. 9/02

DEPARTMENT OF HEALTH

HEALTH REGULATION & LICENSING

ADMINISTRATION

| ND PLAN OF CORRECTION | | The background check and finger print document was filed for the fitness |
|--|--------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | Findings included: | On 05/15/19 at 9:37 AM, the FI was observed working with Resident #1 performing physical exercises in the basement. Beginning at 10:08 AM. |

5/17/19

nstructor.

On 05/16/19 at 10:45 AM, review of the personnel the fitness instructor was observed working with Resident #2 performing physical exercises.

exercises in the basement. Beginning at 10:08 AM,

file maintained for the fitness instructor revealed no evidence of a criminal background check.

criminal background check for any fitness instructor about a background check. She also agreed to ask and the fitness company required them to submit a On 05/16/19 at 11:09 AM, the QA stated that she would ask the agency's human resources officer sent to work with the residents of this facility. No whether the written contract between the GHIID additional information was shared before the survey ended.

At the time of the survey, the facility failed to show evidence that they had obtained a finger print or live scan for the fitness instructor. 3