STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G255	A. BUILDING _____ B. WING _____	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI-SERVICES	[redacted] WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 08/22/18 through 08/23/18. Two clients were selected from a population of four women 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 QIDP - Qualified Intellectual Disabilities Professional	W 000		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each staff was trained effectively to implement each client's feeding protocol, for the one (1) of two (2) clients in the core sample with a modified diet. (Client #2) Findings included: On 08/23/18, at 7:26 AM, observations showed Client #2 had several missing upper and lower	W 192		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Courtanell A. Reese | TITLE: Program Director | (X6) DATE: 9/11/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 192	Continued From page 1 incisors. The client was served bite-size toast with peanut butter, a bowl of bran flakes with 2% milk and a cup of orange juice. Further observation showed the client eating bite-size toast with peanut butter without any liquids. Further observations showed that the resident coughed twice while eating the toast with peanut butter. On 08/23/18, one (1) minute later DSP #2 was queried about Client #2's coughing. DSP #2 said that Client #2 should take sips of liquids throughout the meal to help prevent choking. DSP#2 then offered the client orange juice to alternate with the toast and peanut butter. On 08/23/18, at 2:05 PM, the QIDP said that all staff had been trained on Client #2's feeding protocol. On 08/23/18, at 2:15 PM, review of Client #2's feeding protocol dated 04/26/18 showed that the resident should alternate solids and liquids throughout the meal to facilitate swallowing. On 08/23/18, at 3:00 PM, review of the facility's in-service training records showed all staff including DPS #2 received training on Client #2's mealtime protocol on 11/20/17. At the time of the survey, the facility failed to ensure all staff was effectively trained to implement Client #2's mealtime protocol, as recommended.	W 192	DSP#2 will be retrained on Client #2's meal time protocol. QIDP will continue to monitor meals.	9/30/18

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E 000	Initial Comments	E 000		

An emergency preparedness survey was conducted from 08/22/18 through 08/23/18.

The findings of the survey were based on observations, interviews and review of the emergency preparedness program.

Note: The below are abbreviations that may appear throughout the body of this report.

EP - Emergency Plan
EPP -Emergency Preparedness Plan
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse

E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)	E 006		

[(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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Constance A. Reese	Program Director	9/11/18

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 observation, interview and record review, the facility failed to develop an all-hazard facility-based and community-based risk assessment to identify potential hazards (Gas Leak) essential to the facility's geographic location, for four (4) of 4 clients residing in the facility (Clients #1, 2, 3 and 4). Findings included. On 08/22/18, at 3:35 PM, observation of the facility's location showed that a shell gas station was located directly across from the facility approximately one-hundred feet away or less. On 08/22/18 beginning at 3:46 PM, the QIDP said during an interview that the facility had identified snowstorms, blizzards, flooding, tornado, thunderstorms, hurricanes, crime, earthquakes, etc. posed moderate to low hazards for this facility's location. On 02/23/18 beginning at 1:30 PM, review of the facility's risk assessment (December 2017) verified the QIDP's interview that snowstorms, blizzards, flooding, tornado, thunderstorms, crime, hurricanes and earthquakes were assessed to be moderate to low hazards for this	E 006		

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E 006	Continued From page 2 facility's location. At 1:59 PM, a follow-up interview was conducted with the QIDP regarding the risk assessments. When asked why gas leaks were not part of their risk assessment given that the shell gas station was located directed across from the facility, the QIDP responded by say, "I did not think about that". The QIDP then stated that a gas leak would be a potential hazard for this location. The QIDP further stated that she would talk with her supervisor about this concern. At the time of the survey, the facility failed to develop an all-hazard facility-based and community-based risk assessment to identify the potential hazards specific to their geographic location.	E 006	The facility will develop an all-hazard facility based and community based risk assessment that will identify potential hazards specific to this facility's location to include living across from a gas station! 9/21/18	
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	E 007		

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E 007	Continued From page 3 failed ensure the EP identified which staff would assume the leadership role during an emergency, for four (4) of 4 clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 08/23/18, at 2:03 PM, review of the facility's EP, dated December 2017 showed no documented evidence which staff on each shift would be responsible for the leadership role during an emergency. At 4:05 PM, an interview was conducted with the QIDP regarding staff assuming specific leadership roles during an emergency. The QIDP stated that there was no written authorized staff member responsible on each shift to assume the leadership role during an emergency. At the time of the survey, the facility failed to ensure that the EP identified which staff member would assume the leadership role if the QIDP, RN and administrator could not be reached during an emergency.	E 007	The facility's EP will identify a staff member for each shift that will assume the leadership role if the management cannot be contacted during an emergency. QIDP will provide necessary training for the staff members assigned to each shift.	9/21/18
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [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 address the following:	E 015		

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E 015	Continued From page 4	E 015		

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility

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E 015	Continued From page 5 failed to develop written policies and procedures to ensure adequate alternate energy sources necessary to maintain temperatures during emergency situations, for four (4) of 4 clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 08/23/18 beginning at 1:30 PM, review of the facility's EP dated December 2017 showed no evidence that policies and procedures had been developed to maintain temperatures during emergencies. During an interview on 08/23/18 at 4:20 PM, the QIDP confirmed that there were no policy and procedures specifically addressing temperatures during emergencies. At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed temperature to protect the health and safety and sanitary provisions during emergency situations.	E 015	The facility's EP Plan will be updated to include Policy and Procedures that will address what to do in the event of temperature control failure during an emergency situation. QIDP will train staff on policy.	9/21/18
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(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 address the following:]	E 024		

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E 024	Continued From page 6 (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures that address the use of volunteers during an emergency, for four (4) of 4 clients residing in the facility. (Clients #1, 2, 3 and 4) Findings included: On 08/23/18, at 12:59 PM, review of the facility's EP, dated December 2017 showed no evidence that policies and procedures had been developed to address how and if the facility would use volunteers during emergencies. On 08/23/18, at 3:45 PM, the QIDP said during an interview that the facility would not use volunteers during emergency situations. When asked if there were policies and procedures related to volunteers in the EPP, the QIDP responded by saying, "no". At the time of the survey, there was no evidence that the facility's EP addressed the use of volunteers during emergencies.	E 024	The facility's Policy & Procedures will be updated to address the use of volunteers during emergency situations. Citizen Corp Programs will be contacted for support and assistance.	9/21/18
E 035	LTC and ICF/IID Sharing Plan with Patients	E 035		

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E 035	Continued From page 7 CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client's family member or representative had been given information regarding the facility's emergency plan, for four (4) of 4 clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 08/23/18, beginning at 1:30 PM, review of the facility's EP communication plan dated December 2017 showed the primary and alternate means for communicating with family members and guardians were via telephone and e-mails. At 3:50 PM, the QIDP said during an interview that she had not contacted the clients' family members and/or guardians via telephone or e-mail regarding the facility's EP information. The QIDP stated that she would e-mail the clients' family members and guardians the facility's EPP as soon as she gets a chance to do so. At the time of the survey, the facility failed to ensure the clients' family members and/or	E 035	QIDP notified family members and/or guardians via email, regarding facility's EP information.	9/6/18

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E 035	Continued From page 8 guardians were made aware of the facility's EPP once the plan had been developed.	E 035	The facility developed a written plan for the EPP that contains methods within the Communication Plan that will give guidance for sharing information with the Clients' families or representatives during an emergency.	9/1/18

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	HFD03-2888	A. BUILDING: _____ B. WING _____	08/23/2018

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I 000	INITIAL COMMENTS A licensure survey was conducted from 08/22/18 through 08/23/18. A sample of two residents was selected from a population of four females with various degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and reviews 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 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observations, interview and record review, the GHIID failed to ensure that each staff was trained effectively to implement each client's feeding protocol, for the one (1) of two (2) residents in the core sample with a modified diet. (Resident #2) Findings included: On 08/23/18, at 7:26 AM, observations showed Resident #2 who had missing upper and lower	I 042		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 042	Continued From page 1 incisors and was served bite-size toast with peanut butter, a bowl of bran flakes with 2% milk and a cup of orange juice. Further observation showed the Resident eating bite-size toast with peanut butter without any liquids. Further observations showed that the resident coughed twice while eating the toast with peanut butter. On 08/23/18, one (1) minute later DSP #2 was queried about Resident #2's coughing. DSP #2 said that Resident #2 should take sips of liquids throughout the meal to help prevent choking. DSP#2 then offered the resident orange juice to alternate with the toast and peanut butter. On 08/23/18, at 2:05 PM, the QIDP said that all staff had been trained on Resident #2's feeding protocol. On 08/23/18, at 2:15 PM, review of Resident #2's feeding protocol dated 04/26/18 showed that the resident should alternate solids and liquids throughout the meal to facilitate swallowing. On 08/23/18, at 3:50 PM, review of the facility's in-service training records showed all staff including DPS #2 received training on Resident #2's mealtime protocol on 11/20/17. At the time of the survey, the facility failed to ensure all staff was effectively trained to implement Resident #2's mealtime protocol, as recommended.	I 042	DSP #2 will be retrained on Client #2's meal time protocol. QIDP will continue to monitor meals.	9/30/18