

DC Health Regulation and Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0251		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/15/2026	
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW, WASHINGTON, District of Columbia, 20011			
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10000	Initial Comments An annual relicensure survey was conducted at this facility from April 13, 2026, through April 15, 2026. A sample of two persons was selected from a census of four. The findings of the survey were based on observations, interviews, and record reviews.			10000	Please start typing your responses here:		
17920	PERSONNEL CFR(s): 3512.12 3512.12 Each employee, within ninety (90) days prior to employment and annually thereafter, shall provide certification from a physician attesting that he or she is fit to perform the required duties of the job and is free from any active communicable disease. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that the physician provided certification verifying that staff were fit to perform their required duties and are free from active communicable disease for six (Direct Support Professionals (DSPs) #1, #9, #10, #11, #12 and #16). Findings included: Observations throughout the survey period, beginning on April 13, 2026, at 10:37 AM, showed DSP #1, DSP #9, DSP #10, DSP #11, DSP #12 and DSP #16 in the home actively providing services for the persons which included guiding and assisting persons in their active treatment programs, preparing and serving meals, conducting observations, and completing other support tasks. On April 15, 2026, at 11:28 AM, a review of the facility's personnel records, provided by the Quality Assurance Specialist (QAS), revealed that documentation confirming that the DSPs had been evaluated by a health care professional were expired/ outdated as follows, for DSP #1 (5/11/2024), DSP #9			17920			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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I7920	Continued from page 1 (12/18/2024), DSP #10 (11/19/2024), DSP #11 (7/24/2024), DSP #12 (9/19/2024), and DSP #16 (11/29/2024). At 2:49 PM, the Quality Assurance Specialist (QAS), who provided the personnel records, reviewed the documents and acknowledged the findings.			I7920			
I7930	PERSONNEL CFR(s): 3512.13 3512.13 The CRFPID shall comply with and shall not employ a worker who does not comply with District of Columbia standards on criminal background checks as set out in D.C. Law 14-98, the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002 and implementing regulations, 22B DCMR Chapter 47. The CRFPID shall obtain enough information from each applicant to comply with criminal background check requirements even if obtaining such information is in addition to information obtained in compliance with Subsection 3512.14. In addition, each CRFPID shall comply with background checks in accordance with applicable federal law and shall not employ a person who has a history of the following: (a) Child abuse or abuse of someone under his or her care and supervision, including misappropriation of property; (b) Neglect; (c) Exploitation; (d) Conviction for a sexual offense or violent crime; or (e) A conviction for criminal violation(s) that would indicate behavior potentially harmful to persons. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete the employee criminal background checks as required (Direct			I7930			

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17930	Continued from page 2 Support Professionals (DSPs) #1, #5, #8, #9, and #14). Findings included: Observations throughout the survey period, beginning on April 13, 2026, at 10:37 AM, showed DSP #1, DSP #5, DSP #8, DSP #9, and DSP #14 in the facility providing services, including guiding and assisting persons in their active treatment programs, meal preparation and service, observation, and other support tasks. On April 15, 2026, at 11:28 AM, a review of facility provided personnel records revealed that there was no background check documentation completed by the Department verifying employment eligibility for DSP #1, DSP #5, DSP #8, DSP #9, and DSP #14. At 2:49 PM, the Quality Assurance Specialist who presented the personnel records for review acknowledged the findings.	17930			
18270	STAFF TRAINING CFR(s): 3515.7 3515.7 The CRFPID shall provide on-the-job training as necessary for the performance of job assignments in accordance with the requirements of this section. Employees shall be directly supervised until the Residence Director or QIDP deems that competence in the performance of all job duties has been achieved. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide necessary on the job training to ensure that staff demonstrated competency in performing required job duties, specifically in implementing (1) the use of a gait belt (Person #3), (2) the prescribed fluid intake (Persons #2 and #3), and (3) the ordered calorie meal plan (Person #3). Findings included: 1) The review of Client #3's records revealed that the client had a prior fall with fractures and was assessed as being at a high risk for falls. Further review revealed orders that indicated that the client required 1:1 supervision, fall precautions, and the use of a gait belt.	18270			

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I8270	Continued from page 3 A review of the facility's training records documented that all the Direct Support Professionals (DSPs) were trained on Client #3's Health Care Management Plan (HCMP) which included the client's fall risk and fall precautions on 01/26/2026. Observations on April 13 and 14, 2026, showed Client #3 repeatedly walking without wearing a gait belt, despite staff being present. During an interview on April 15, 2026, DSP #7 and the registered nurse (RN) acknowledged that Client #3 is required to wear a gait belt when walking. The RN stated that she would retrain staff. 2) The review of Persons #2 and #3 records showed that both were ordered to receive six – eight (6–8) glasses of water daily. A review of facility's training records indicated that on January 26, 2026, the Registered Nurse (RN) provided staff training on Client #2 and #3's Health Care Management Plan, including instruction on the persons intake procedures. On April 14, 2026, at 1:32 PM, a review of Client #2's intake record revealed that the client had three days where fluid intake was high, with more than eight glasses of water and more than three glasses of other fluids, and the documentation also showed one day where intake was low, with only three glasses of water and one glass of milk, totaling fewer than six glasses overall. A review of Client #3's intake record revealed that the client had three days with high fluid intake, receiving more than eight glasses of water and more than three glasses of additional fluids. In an interview on April 15, 2026, at 2:12 PM, before the exit, the RN acknowledged the finding and stated she would seek a recommendation from the nutritionist and retrain the employees on persons' intake procedures, including how to measure and record intake accurately. The review of Client #3's Physician Order Sheet (POS) revealed a diagnosis of obesity and a prescribed 1200kcal diet that is low fat, low cholesterol, high fiber, low carbohydrate, and free of concentrated sweets. The client's Health Care Management Plan (HCMP) requires Direct Support Professionals (DSPs) to offer and encourage adherence to this diet. Further review of the	I8270			

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18270	Continued from page 4 facility's training records confirmed that the RN on January 23, 2026, had trained all the staff, including DSP's #9 and #13, on the client's HCMP and the requirement to follow the client's prescribed diet. Observations during lunch on April 13, 2026, at 11:54 AM, showed that Client #3 received the same food portions as all the other persons, based on the facility's 1500kcal menu. On April 15, 2026, at 10:34 AM, a review of the facility's menu confirmed that a designated 1200kcal, low cholesterol portion was available for staff to follow. When asked during an interview at 1:13 PM, DSP #9 stated that she was unaware that Client #3 required a different diet and indicated she would follow the 1200kcal portion going forward. During an interview at 2:03 PM, the RN acknowledged the findings and stated that the facility would provide additional retraining.	18270			
19730	EMERGENCIES CFR(s): 3523.13 3523.13 In addition to the reporting requirement in Subsection 3523.10, each CRFPID shall notify the Department of any other unusual incident that substantially interferes with a person's health, welfare, living arrangement or well-being or in any other way places a person at risk. Such notification shall be made by telephone immediately when the staff is aware and shall be followed up by written notification within twenty-four (24) hours or the next business day. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to report to the Department an unusual incident (serious physical injury) a fall related fracture by telephone immediately and written notification within 24 hours or the next business day as required for one of the four persons in the facility (Person #3) Findings included: On April 13, 2026, beginning at 3:21 PM, the review of an incident investigation report dated December 12, 2025, indicated that Client #3 experienced a fall on August 6, 2025. Per the report, Person #3 was	19730			

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19730	Continued from page 5 evaluated by her Primary Care Physician (PCP) through StationMD on August 6, 2025, and again during a follow-up visit on August 8, 2025. Person #3 was treated for soft tissue swelling of the left leg, as shown on the x-ray results. The report further documented that an orthopedic consultation on September 4, 2025, revealed a mildly displaced fracture of the proximal left fibular diaphysis with signs of healing, as well as a likely Lisfranc fracture involving the tarsometatarsal joints. The investigation concluded that no abuse or neglect was identified. On April 15, 2026, at 12:06 PM, a review of the facility's incident reporting records showed no documented evidence that the fall involving Person #3 was reported to the Department of Health, either by immediate telephone notification or required written follow-up, despite the later discovery of a fracture. When asked during an interview at 12:43 PM, the registered nurse (RN) indicated that she did not report the fall at the time it occurred because she was unaware that it required immediate notification to the Department of Health. The RN stated that she only became aware of the reporting requirement later, when the facility's incident investigator reminded her during the subsequent investigation.	19730			
19780	EMERGENCIES CFR(s): 3523.18 3523.18 Each CRFPID shall conduct fire drills in order to test the effectiveness of the plan at least once every three months for each shift. An actual evacuation must be documented during at least one drill, each year on each shift. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record reviews, the facility failed to conduct the quarterly evacuation drills on each of the three shifts as required (12:00 AM–8:00 AM, 8:00 AM–4:00 PM, and 4:00 PM–12:00 PM). Findings included: During the entrance conference on April 13, 2026, at 12:40 PM, the facility's Qualified Intellectual Disabilities Professional indicated that the facility operates three shifts: 12:00 AM–8:00 AM, 8:00 AM–4:00 PM, and 4:00 PM–12:00 AM, Monday	19780			

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I9780	Continued from page 6 through Sunday. On April 15, 2026, at 9:23 AM a review of the facility's fire and emergency drill records revealed that on the 12:00 AM–8:00 AM shift or the 4:00 PM–12:00 AM shift from June 2025 through December 2025, no evacuation or fire drills with evacuation participation were conducted. During this period, the only documented drill was one emergency drill conducted on August 16, 2025, on the 8:00 AM–4:00 PM shift. Further review showed that from January 2026 till date, the facility had only completed one fire drill, also on the 8:00 AM–4:00 PM shift. In an interview at 12:21 PM, when asked about the missing drill documentation, the Quality Assurance Specialist (QAS)—who had provided the records for review stated that he would contact personnel in the main office responsible for coordinating the drills. At 3:10 PM, prior to the survey exit meeting, the QAS informed the surveyor that he had contacted the main office but was unable to obtain any additional fire or emergency drill documentation for the missing periods.			I9780			