

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0000	Initial Comments An emergency preparedness survey was conducted at this facility from 08/18/2026 through 08/21/2026. The findings of the survey were based on observations, interview and record reviews.	E0000	Please start typing your responses here:		
W0000	INITIAL COMMENTS A recertification survey was conducted at this facility from 08/18/2026 through 08/21/2026. Two clients were selected from a census of two. The survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews, and the review of client and administrative records.	W0000			
E0007	EP Program Patient Population CFR(s): 483.475(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. 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. ** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. The plan must do all of the following:	E0007			

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 reverse for further 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	TITLE	(X6) DATE
---	-------	-----------

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0007	Continued from page 1 (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC 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 observations, interviews, and record reviews, the facility's Emergency Preparedness Plan (EPP) and/or individualized Personal Emergency Preparedness Plan (PEPP) failed to address each client's assessed needs that placed the client at risk, for one of two clients residing in the facility (Client #2). Findings included: 1. A review of Client #2's Emergency Preparedness Plan (EPP) and/or individualized Personal Emergency Preparedness Plan (PEPP) dated 04/30/2026 failed to show the guidelines to ensure staff informed the client of what he was being served and that staff described the placement of food items and the location of the cup, glass, bowl, utensils, etc. A review of Client #2's Mealtime Guidelines dated 04/30/2026, indicated that staff must name the food that is being served, describe placement of food items and location of cup, glass, bowl, utensils, etc. Observations beginning at 7:07 AM showed that Client #2 was visually impaired. At 5:48 PM, Client #2 was served a hamburger, potato tots, juice and water. During this time, staff did not inform the client what he was having for dinner or describe the placement of foods, utensils, water and juice. On 08/21/2026 at 1:35 PM, the finding was shared with the Qualified Intellectual Disabilities Professional (QIDP), who acknowledged that the guideline was not addressed in Client #2's PEPP. 2. Review of Client #2's EPP and/or PEPP dated 04/30/2026 failed to address the use of the client's wheelchair On 08/18/2026 at 9:00 AM, observations confirmed that Client #2 utilized a wheelchair.	E0007			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011			
(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
E0007	Continued from page 2 A review of the EPP and/or PEPP dated 04/30/2026 showed no documentation regarding the client's wheelchair needs. During an interview on 08/21/2026 at 1:35 PM, the QIDP acknowledged that the client's wheelchair use was not addressed in the EPP and/or PEPP. 3. A review of Clients #1 and #2's EPP and/or PEPP dated 04/30/2026 showed that the facility identified the front door and the basement door as evacuation routes. However, further review showed no evidence that the facility identified the back door on the first floor or the fire escape door on the second floor as additional means of egress during an emergency. During an interview on 08/21/2026 at 1:42 PM, the QIDP acknowledged that all means of egress were not addressed in the EPP and/or PEPP.			E0007			
E0030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility 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 every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all			E0030			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0030	Continued from page 3 of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians.	E0030			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0030	Continued from page 4 (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to include in its Communication Plan the names and contact information for each direct support staff employed, for two of two clients residing in the facility (Clients #1 and #2). Findings included: On 08/21/2026 beginning at 10:28 AM, a review of the facility's Communication Plan (updated 01/01/2026) and the current staff schedule showed no evidence that the facility had updated its list of staff names and contact information. On 08/21/2026 at 12:40 PM, interview with the Qualified Intellectual Disabilities Professional (QIDP) confirmed that the Communication Plan did not include a current list of staff names and contact information.	E0030			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and	E0039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011			
(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
E0039	Continued from page 6 emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community-based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual			E0039			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011			
(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	
E0039	Continued from page 7 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:	E0039					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0039	Continued from page 8 (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or	E0039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
E0039	Continued from page 9 prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d):]	E0039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011			
(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	
E0039	Continued from page 10 (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or	E0039					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011			
(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
E0039	Continued from page 11 man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.			E0039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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
E0039	Continued from page 12 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to conduct a full-scale or tabletop exercise to test and analyze the facility's emergency plan for two of two clients residing in the facility (Clients #1 and #2). Findings included: On 08/21/2026, beginning at 10:15 AM, a review of the facility's policies and procedures dated 01/01/2026, and other emergency preparedness documentations revealed no documented evidence that the facility had participated in a full-scale or tabletop exercise. During an interview on 08/21/2026 at 11:30 AM, the Qualified Intellectual Disabilities Professional (QIDP) stated that facility had not conducted a full-scale or tabletop activity.	E0039			
W0130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure privacy during personal care needs, for two of two clients residing in the facility (Clients #1 and #2). Findings included:	W0130			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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
W0130	Continued from page 13 1. On 08/18/2026 at 7:02 AM, Direct Support Professional (DSP) #1 informed the surveyor that she was providing personal hygiene care. At 7:05 AM, Client #1 was observed walking in her bedroom wearing only underwear, with the bedroom door fully open. DSP #1 was also observed in client #1's bedroom. At 7:07 AM, DSP #1 partially closed the bedroom door. Client #2 and DSP #2 were observed within close proximity at this time. During an interview at 7:25 AM, DSP #1 acknowledged that the bedroom door should have been closed to ensure Client #1's privacy. 2. On 08/20/2026 at 3:55 PM, Client #2 was observed sitting on the toilet with his pants down, exposing his legs and buttocks, while the bathroom door was partially open. During this time, Client #1 and staff were observed within close proximity. During an interview at 4:01 PM regarding client privacy during personal care needs, DSP #5 stated that the bathroom door should have been closed to ensure Client #2's privacy.	W0130			
W0140	CLIENT FINANCES CFR(s): 483.420(b)(1)(i) The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to provide evidence or receipts that justified the withdrawals/expenditures from each client's personal account, for two of two clients in the sample (Clients #1 and #2). Findings included: An Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 08/18/2026 at 9:50 AM, revealed that the facility assisted the clients with maintaining their finances. A review of each client's financial records revealed the following: On 08/21/2026, beginning at 12:08 PM, a review of Client #1's bank statements revealed that \$400.00	W0140			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011	
(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
W0140	Continued from page 14 was withdrawn on 02/20/2026 from the client's account. Further review showed that no receipts were available to justify the withdrawal. Similarly, a review of Client #2's bank statements revealed that \$400.00 was withdrawn on 02/20/2026 and \$500.00 was withdrawn on 03/18/2026, totaling \$900.00. Further review showed that there were receipts to justify \$604.37, but no receipts were available to justify the remaining \$295.63. During an interview at 2:00 PM, the House Manager (HM) and QIDP confirmed the findings and acknowledged that there were no receipts in the record to account for the unverified amounts.	W0140		
W0185	FACILITY STAFFING CFR(s): 483.430(c)(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is NOT MET as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure there was a sufficient number of staff on duty to make certain chore activities did not interfere with established one to one (1:1) duties and responsibilities, for one of two clients residing in the facility (Client #2). Findings included: [Cross Refer to W 249] A review of Client #2's Behavior Support Plan (BSP) dated 04/09/2026 indicated that the client required 24 hour 1:1 staff supervision "due to vision loss, fall risk status (especially when attempting to get off bed and use bathroom as before the vision loss), and loss of balance while standing or walking. " On 08/18/2026, beginning at 4:39 PM, evening observations showed that Client #2 was left alone in the television room while his 1:1 staff, Direct Support Professional (DSP #5) was in the kitchen cooking dinner for the clients. On 08/20/2026 at 3:55 PM, Client #2 was observed alone in the bathroom while his 1:1 staff, DSP #5 went outside into the backyard for approximately 2 minutes. During an interview on 08/20/2026 at 4:45 PM, the Qualified Intellectual Disabilities Professional	W0185		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0185	Continued from page 15 (QIDP) stated that Client # 2 should not have been left alone and acknowledged that the client required 1:1 support within arm's length at all times.	W0185			
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that each client's Behavior Support Plan (BSP) was consistently implemented for one of two clients residing in the facility (Client #2). Findings included: A review of Client #2's BSP dated 04/09/2026 indicated that the client required 24 hour 1:1 staff supervision "due to vision loss, fall risk status (especially when attempting to get off bed and use bathroom as before the vision loss), and loss of balance while standing or walking. " On 08/18/2026 beginning at 4:39 PM, evening observations revealed that Client #2 was left alone in the television room while his 1:1 staff Direct Support Professional (DSP #5) was observed in the kitchen cooking dinner for the clients. On 08/20/2026 at 3:55 PM, Client #2 was left alone in the bathroom while his 1:1 staff DSP #5 went outside into the backyard for approximately 2 minutes. During an interview on 08/20/2026 at 4:45 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated that Client # 2 should not have been left alone and acknowledged that the client required 1:1 support within arm's length at all times.	W0249			
W0368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W0368			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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
W0368	Continued from page 16 This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that each client's prescribed medications were administered in accordance with the physician's orders for one of two clients residing in the facility (Clients #2). Findings included: A review of Client #2's Physician Order sheet (POS) dated 08/01/ 2026, revealed that Levothyroxine 75mcg was scheduled to be administered at 6:30 AM. Observations on 08/18/2026 at 7:47 AM, showed that the Licensed Practical Nurse (LPN) administered Client #1's medication mixed with applesauce. During an interview on 08/20/2026 at 2:38 PM, the LPN acknowledged that the medication was administered later than the ordered 6:30 AM time. Further review of Client #2's POS showed an order to administer Levothyroxine 30 minutes before breakfast. However, observations on 08/18/2026, showed Client #2 completed his breakfast at 8:09 AM. During an interview at 8:34 AM, Direct Support Professional stated that she did not check the time before serving Client #2's breakfast. When asked how long the client took to eat, the DSP stated approximately 15 to 20 minutes.	W0368			
W0369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that each client's prescribed medications were administered without error for one of the two clients residing in the facility (Client #2). Findings included: A review of Client #2's Physician Order sheet (POS) dated 08/01/ 2026, revealed that Levothyroxine	W0369			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0369	Continued from page 17 75mcg was scheduled to be administered at 6:30 AM. Observations on 08/18/2026 at 7:47 AM, showed that the Licensed Practical Nurse (LPN) administered Client #1's medication mixed with applesauce. During an interview on 08/20/2026 at 2:38 PM, the LPN acknowledged that the medication was administered later than the ordered 6:30 AM time. Further review of Client #2's POS showed an order to administer Levothyroxine 30 minutes before breakfast. However, observations on 08/18/2026, showed Client #2 completed his breakfast at 8:09 AM. During an interview at 8:34 AM, Direct Support Professional stated that she did not check the time before serving Client #2's breakfast. When asked how long the client took to eat, the DSP stated approximately 15 to 20 minutes.	W0369			
W0371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to afford each client the opportunity to participate in self-medication to the extent of their abilities for two of two clients residing in the facility (Clients #1 and #2). Findings included: 1. A review of Client #1's Individual Program Plan (IPP) dated August 2026, showed the client had a training objective that indicated the client will participate in a self-medication program with gestural assistance. According to the objective, the client will complete the steps of self-administering her medications 60% of recorded trials per month for 12 consecutive months. The programs objectives listed that Client #1 will:	W0371			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0371	Continued from page 18 - wash her hands - fill a glass of water - Identify medications to be punched - hold cup under medicine to be punched - punch medication into cup Observations on 08/18/2026 beginning at 8:02 AM, showed the Licensed Practical Nurse (LPN) retrieved Client #1's medications from the medication cabinet and poured a glass of water for the client. The LPN then dispensed hand sanitizer into the client's hand. After Client #1 sanitized her hands, the client punched medications into the medication cup with hand over hand assistance from the LPN. On 08/20/2026 at 3:30 PM, the LPN confirmed that the client was not encouraged to complete all steps of the program. The LPN then stated that Client #1 was not encouraged to pour her own water because the container was heavy. 2. On 08/20/2026 at 12:50 PM, a review of Client #2's Self-Administration of Medication (SAM) assessment tool dated 04/24/2025, showed that no self-medication program had been recommended for the client. Observations on 08/18/2026, beginning at 7:36 AM, showed the LPN prepared and spoon-fed Client #2's medications without any participation from the client. At 3:19 PM, Client #2 was observed participating in tabletop activities. When the client heard the surveyors voice, he said her name. At 5:45 PM, Client #2 brought his plate to the dining room table with assistance from Direct Support Professional (DSP) #5 and was then observed eating dinner independently after staff setup. During an interview at approximately 8:00 AM, the LPN stated that Client #2 was not recommended for a self-medication program because he was blind.	W0371			
W0381	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(1) The facility must store drugs under proper	W0381			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0381	Continued from page 19 conditions of security. This STANDARD is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to store medications under proper condition of security, for two of two clients residing in the facility (Clients #1 and #2). Findings included: On 08/18/2026, at 7:36 AM, the Licensed Practical Nurse (LPN) was observed preparing Client #2's medication at the medication closet. At 7:41 AM, the LPN left the medication door open as she walked into the dining room. Further observation showed Client #1 Levothyroxine in bowl covered on the kitchen counter while the LPN was in the dining room. During this time, all the clients and facility staff were in close proximity to the unsecured medications. During an interview at approximately 7:45 AM, the LPN acknowledged that the Clients' medications had been left unsecured and confirmed that she should have properly secured them.	W0381			
W0436	SPACE AND EQUIPMENT I CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain and provide each client with the recommended adaptive equipment, specifically a wheelchair, for one of two clients residing in the facility (Client #2). A review of Client #2's Annual Physical Therapy evaluation dated 04/20/2026, revealed the client's wheelchair "frame is bent such that the seat does not sit properly in the bracket. The right armrest cushion is worn. The waist belt is attached on the uprights such that the waist belt is positioned across his abdomen. This is not optimal." Further review indicated that the client may benefit from a custom wheelchair, as he utilizes the wheelchair consistently for community outings.	W0436			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0436	Continued from page 20 A review of the Primary Care Physician order dated 07/20/2026 showed an order for a customized manual wheelchair for Client #2. On 08/18/2026 at 9:00 AM, observations of Client #2's wheelchair showed that the right armrest cushion was worn. Continued observations showed an additional seat pad placed on the wheelchair seat due to the bent frame. During an interview on 08/21/2026 at 1:35 PM, the Licensed Practical Nurse (LPN) confirmed that Client #2's wheelchair was not properly maintained and that the recommended replacement had not been addressed in a timely manner.	W0436			
W0455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure proper infection control procedures were implemented, for two of two clients residing in the facility (Clients #1 and #2). Findings included: On 08/20/2026 at approximately 4:00 PM, a review of the facility's in-service training records indicated that staff were trained on infection control practices to prevent the spread of disease on 05/04/2026. On 08/18/2026 at 7:18 AM, Client #1 was observed sitting in the living room coughing. At 7:43 AM, while the client sat at the dining room table, Client #1 began to cough again without any encouragement from staff to cover her mouth. At 7:58 AM, after Client #1 completed her breakfast, Direct Support Professional (DSP) #1 instructed the client to take the place mat to the kitchen. Client #1 walked into the kitchen with DSP #1 and placed the mat on top of the refrigerator without cleaning it. Continued observation showed that the dining room table was not wiped clean after the dishes and place mat were removed. At 8:45 AM, DSP #1 was interviewed regarding cleaning and disinfecting practices during mealtimes. DSP #1 confirmed that she did not encourage Client	W0455			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0455	Continued from page 21 #1 to clean the place mat before placing it on top of the refrigerator and stated she will clean now. Later at 3:42 PM, DSP #4 asked Client #1 to sit at the dining room table to participate in tabletop activities. As the client walked towards the table, mucus was observed hanging from the client's nose to her mouth. After the surveyor brought this to DSP #4's attention, DSP #4 retrieved a paper towel and instructed the client to wipe her nose. Once the client wiped her nose and held the paper towel in her hand, DSP #4 took the paper towel without instructing the client to wash her hands. At 3:45 PM, DSP #4 was interviewed regarding hand hygiene practices during personal care. DSP #4 stated that it was routine for staff and clients to wash their hands after personal care. DSP #4 then instructed the client to accompany her to the bathroom to wash her hands.	W0455			
W0474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that each client was served meals in the form and consistency prescribed, for one of two clients residing in the facility (Client #2). Findings included: A review of Client #2's Mealtime Guidelines dated 04/30/2026 indicated that the client required a Mechanical soft chopped, pea-sized or cheerio diet. Bite-size sandwiches with meats mechanically chopped were recommended, and the client may have seconds if desired. On 08/18/2026 beginning at 7:43 AM, breakfast observations showed that Client #2 was served an egg sandwich cut in half. On 08/19/2026 at 1:40 PM, lunch observations showed that Client #2 was served a bite-size hamburger and potato tots. During an interview at 8:16 AM, the Direct Support Professional (DSP) #2 stated that Client #2's sandwich was cut in half because he does not like bite size sandwiches.	W0474			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II				STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011			
(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
W0478	MENUS CFR(s): 483.480(c)(1)(ii) Menus must provide a variety of foods at each meal. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure each client was provided with a variety of foods and that substitutions were made with foods of similar nutritional value for two of two clients residing in the facility (Clients #1 and #2). Findings included: 1. On 08/18/2026, beginning at 7:43 AM, breakfast observations showed that Clients #1 and #2 were served eggs, bread, cereal, juice and water. A review of the breakfast menu for 08/18/2026, showed that the clients should have received turkey sausage, toast, raisin bran, juice, and milk or water. At 8:20 AM, Direct Support Professional (DSP) #1 stated that the items listed on the breakfast menu were not available. 2. On 08/18/2026 at approximately 7:15 AM, DSP #1 was observed taking a hamburger from the refrigerator to cook. Observation at Client #2's day program showed the client was drinking his ensure. When asked what Client #2 had for lunch, the 1:1 staff (DSP #3) stated that client #2 had a hamburger and fries. A review of the lunch menu for 08/18/2026, showed that the client should have received chicken salad, bread, sweet pickles, potato chips, peaches, and a beverage. Continued observations during dinner beginning at 5:48 PM, showed that Client #1 was served a hamburger, potato salad, broccoli, juice and water was served. Client #2 was served a hamburger, potato tots, juice and water. A review of the dinner menu for 08/18/2026, showed that the clients should have received country steak, mashed potatoes, glazed carrots, dinner roll, cherry pie and a beverage. On 08/19/2026, at 1:40 AM, observations during lunch showed that Client #2 was served hamburger			W0478			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G056	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2026	
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 EMERSON STREET NW, WASHINGTON, District of Columbia, 20011		
(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	
W0478	Continued from page 23 and potato tots again. A review of the lunch menu for 08/19/2026, showed that Client #2 should have received a peanut butter and jelly sandwich, carrot and celery sticks, a banana and a beverage. During an interview on 08/20/2026 at 12:20 PM, the House Manager stated that she was not sure why the clients were not served a variety of foods or provided appropriate nutritional substitutions.	W0478			
W0488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is NOT MET as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that each client was allowed to eat in a manner consistent with his developmental level, for one of two clients residing in the facility (Client #2). Finding included: A review of Client #2's Mealtime Guidelines dated 04/30/2026 revealed instructions to provide bite-sized sandwiches with meats mechanically chopped. The guidelines further indicated that staff should name the food being served and describe the placement of foods and the location of the cup, glass, bowl, utensils, etc. A review of Client #2's Physician Order Sheet dated 08/01/2026 revealed that the client was visually impaired. Observations at dinner on 08/18/2024 beginning at 5:48 PM, showed Client #2 was served a hamburger, potato tots, juice and water. During this time, staff did not tell the client what he was being served and did not describe where the food was located on his plate or the location of his utensil, water, and juice. During an interview on 08/21/2026, at approximately 1:15 PM, the Qualified Intellectual Disabilities Professional (QIDP) confirmed that staff are required to inform the client what he is being served and describe the placement of the food and the location of his set up.	W0488			