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

PRINTED: 07/12/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING ______ B. WING ______	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	[redacted] WASHINGTON, DC 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
W 000	INITIAL COMMENTS A recertification survey was conducted from 06/19/19 to 06/20/19. A sample of two clients was selected from a population of four males. The survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews and review of administrative records. The following abbreviations will appear throughout the report: BSP - Behavior Support Plan DSP - Direct Support Professional LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional PD/QIDP - Program Director/Qualified Intellectual Disabilities Professional	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that staff was effectively trained on implementing each client's BSP, for one of two clients in the core sample. (Client #2) Findings included:	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Adm. Asst. — 7/22/19

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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On 06/19/19 at 05:16 PM, the surveyor opened the front door for Client #2 and his one to one staff (DSP #3) after returning from a community walk. DSP #3 placed himself between the surveyor and Client #2 as they walked inside the facility. Once inside the facility, Client #2 saw another visitor (Clients #3 and 4 barber) standing in the living room. The client immediately ran into the living room and began to hit the barber on the shoulder and barely touching the right side of his face. DSP #3 and DSP #2 both verbally prompted the client to stop and go upstairs to his bedroom. Client #2 complied and went upstairs with DSP #3 and DSP #2.

At 05:15 PM, DSP #3 said during an interview that he did not expect for the surveyor to open the front door which triggered more agitation for Client #2. DSP #3 stated that remained between the surveyor and Client #2 as they entered the facility because of the agitation. DSP #3 further stated that he did not know there was another visitor (Barber) inside the facility which led to Client #2 running in the living room and hitting the Barber. DSP #3 said physical aggression was part of Client #2's BSP and staff was to inform him (client) when visitors are coming to the facility. DSP #3 added that no one told the client or him.

On 06/20/19 at 10:44 AM, review of Client #2's BSP dated 05/31/19 confirmed DSP #3's interview that the client had a maladaptive behavior of physical aggression and attempted physical aggression. Further review of the BSP showed that if Client #2 is physically aggressive (i.e. hitting), redirect him in a calm but firm voice to "stop". Continued review of the BSP revealed

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showed the following proactive strategies:

- Inform [client name] ahead of time if he will be receiving new visitors at his residence or day program.

- When a new visitor arrives at his residence, his one to one should be the one to introduce him to the visitor and let the client know why they are there. This will help put Client #2 at ease.

- Limit the amount of new people [client name] encounters and be to make introductions whenever a new person comes around him.

At 12:25 PM, QIDP #1 said during an interview that she did not inform Client #2 and/or his one to one staff (DSP #3) that there was another visitor inside the facility.

At 1:20 PM, interview with the HM revealed that she did not inform Client #2 and/or DSP #3 that the Barber was inside the facility. The HM stated Client #2 should have been notified as soon as the Barber entered the facility.

Telephone interviews were conducted with the DSP #1 and LPN #4 between 1:25 PM and 1:29 PM. When asked, both DSP #1 and LPN #4 confirmed that they did not inform Client #2 and DSP #3 that there was another visitor inside the facility.

At 1:41 PM, PD/QIDP #2 said during an interview that it was the responsibility of the entire shift to ensure Client #2 was aware that another visitor was inside the facility. When asked, PD/QIDP #2 stated that all staff had been trained on Client #2's BSP. PD/QIDP #2 further stated that he

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W 189	Continued From page 3 would retrain on staff on Client #2's BSP as soon as possible. At 1:47 PM, review of the facility's in-service training records revealed that on 05/31/19, all staff had received training on Client #2's BSP. However, observations on 06/19/19 showed that the training was not effective. At the time of the survey, the facility failed to ensure that Client #2 was informed that another visitor was inside the facility, as recommended by the BSP.	W 189	W 189 - Staff have been retrained on Client #2"s Behavior Support Plan(BSP). The facility's QIDP and House Manager will routinely support staff in implementing and adhering to Client #2's BSP interventions. - Staff shall be retrained semi-annually or as needed on all BSPs.	07/15/19 07/15/19
W 249	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 observation, interview and record review, the facility failed to ensure that each client's BSP was implemented consistently, for one of two clients in the core sample with maladaptive behaviors (Client #2). Findings included: On 06/19/19 at 05:16 PM, the surveyor opened the front door for Client #2 and his one to one	W 249		

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staff (DSP #3) after returning from a community walk. DSP #3 placed himself between the surveyor and Client #2 as they walked inside the facility. Once inside the facility, Client #2 saw another visitor (Clients #3 and 4 barber) standing in the living room. The client immediately ran into the living room and began to hit the barber on the shoulder and barely touching the right side of his face. DSP #3 and DSP #2 both verbally prompted the client to stop and go upstairs to his bedroom. Client #2 complied and went upstairs with DSP #3 and DSP #2.

At 05:15 PM, DSP #3 said during an interview that he did not expect for the surveyor to open the front door which triggered more agitation for Client #2. DSP #3 stated that remained between the surveyor and Client #2 as they entered the facility because of the agitation. DSP #3 further stated that he did not know there was another visitor (Barber) inside the facility which led to Client #2 running in the living room and hitting the Barber. DSP #3 said physical aggression was part of Client #2's BSP and staff was to inform him (client) when visitors are coming to the facility. DSP #3 added that no one told the client or him.

On 06/20/19 at 10:44 AM, review of Client #2's BSP dated 05/31/19 confirmed DSP #3's interview the that client had a maladaptive behavior of physical aggression and attempted physical aggression. Further review of the BSP showed that if Client #2 is physically aggressive (i.e. hitting), redirect him in a calm but firm voice to "stop". Continued review of the BSP revealed showed the following proactive strategies:

- Inform [client name] ahead of time if he will be

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receiving new visitors at his residence or day program.

- When a new visitor arrives at his residence, his one to one should be the one to introduce him to the visitor and let the client know why they are there. This will help put Client #2 at ease.

- Limit the amount of new people [client name] encounters and be to make introductions whenever a new person comes around him.

At 12:25 PM, QIDP #1 said during an interview that she did not inform Client #2 and/or his one to one staff (DSP #3) that there was another visitor inside the facility.

At 1:20 PM, interview with the HM revealed that she did not inform Client #2 and/or DSP #3 that the Barber was inside the facility. The HM stated Client #2 should have been notified as soon as the Barber entered the facility.

Telephone interviews were conducted with the DSP #1 and LPN #4 between 1:25 PM and 1:29 PM. When asked, both DSP #1 and LPN #4 confirmed that they did not inform Client #2 and DSP #3 that there was another visitor inside the facility.

At 1:41 PM, PD/QIDP #2 said during an interview that it was the responsibility of the entire shift to ensure Client #2 was aware that another visitor was inside the facility. When asked, PD/QIDP #2 stated that all staff had been trained on Client #2's BSP. PD/QIDP #2 further stated that he would retrain on staff on Client #2's BSP as soon as possible.

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W 249	Continued From page 6 At the time of the survey, the facility failed to implement Client #2's BSP, as recommended.	W 249	W 249 - Staff have been retrained on Client #2"s Behavior Support Plan (BSP). The facility's QIDP and House Manager will routinely support staff in implementing and adhering to Client #2's BSP interventions	07/15/19
			- Staff shall be retrained semi-annually or as needed on all BSPs.	07/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0127	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 06/20/2019

NAME OF PROVIDER OR SUPPLIER: COMP CARE I I

STREET ADDRESS, CITY, STATE, ZIP CODE: [redacted] WASHINGTON, DC 20011

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I 000	INITIAL COMMENTS A licensure survey was conducted from 06/19/19 to 06/20/19. A sample of two residents was selected from a population of four men. The findings of the survey were based on observations, interviews and review of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. BSP - Behavior Support Plan DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities LPN - Licensed Practical Nurse QIDP - Qualified Intellectual Disabilities Professional PD/QIDP - Program Director/Qualified Intellectual Disabilities Professional	I 000		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure that each Resident's BSP was implemented consistently, for one of two Residents in the core sample with maladaptive behaviors (Resident #2). Findings included: On 06/19/19 at 05:16 PM, the surveyor opened the front door for Resident #2 and his one to one staff (DSP #3) after returning from a community	I 422		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Velma Martin's (signature) TITLE: Adm. Asst. (X6) DATE: 7/22/19

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I 422	Continued From page 1	I 422		

walk. DSP #3 placed himself between the surveyor and Resident #2 as they walked inside the GHIID. Once inside the GHIID, Resident #2 saw another visitor (Residents #3 and 4 barber) standing in the living room. The Resident immediately ran into the living room and began to hit the barber on the shoulder and barely touching the right side of his face. DSP #3 and DSP #2 both verbally prompted the Resident to stop and go upstairs to his bedroom. Resident #2 complied and went upstairs with DSP #3 and DSP #2.

At 05:15 PM, DSP #3 said during an interview that he did not expect for the surveyor to open the front door which triggered more agitation for Resident #2. DSP #3 stated that remained between the surveyor and Resident #2 as they entered the GHIID because of the agitation. DSP #3 further stated that he did not know there was another visitor (Barber) inside the GHIID which led to Resident #2 running in the living room and hitting the Barber. DSP #3 said physical aggression was part of Resident #2's BSP and staff was to inform him (Resident) when visitors are coming to the GHIID. DSP #3 added that no one told the Resident or him.

On 06/20/19 at 10:44 AM, review of Resident #2's BSP dated 05/31/19 confirmed DSP #3's interview that the resident had a maladaptive behavior of physical aggression and attempted physical aggression. Further review of the BSP showed that if Resident #2 is physically aggressive (i.e. hitting), redirect him in a calm but firm voice to "stop". Continued review of the BSP revealed showed the following proactive strategies:

- Inform [Resident name] ahead of time if he will

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be receiving new visitors at his residence or day program.

- When a new visitor arrives at his residence, his one to one should be the one to introduce him to the visitor and let the Resident know why they are there. This will help put Resident #2 at ease.

- Limit the amount of new people [Resident name] encounters and be to make introductions whenever a new person comes around him.

At 12:25 PM, QIDP #1 said during an interview that she did not inform Resident #2 and/or his one to one staff (DSP #3) that there was another visitor inside the GHIID.

At 1:20 PM, interview with the HM revealed that she did not inform Resident #2 and/or DSP #3 that the Barber was inside the GHIID. The HM stated Resident #2 should have been notified as soon as the Barber entered the GHIID.

Telephone interviews were conducted with the DSP #1 and LPN #4 between 1:25 PM and 1:29 PM. When asked, both DSP #1 and LPN #4 confirmed that they did not inform Resident #2 and DSP #3 that there was another visitor inside the GHIID.

At 1:41 PM, PD/QIDP #2 said during an interview that it was the responsibility of the entire shift to ensure Resident #2 was aware that another visitor was inside the GHIID. When asked, PD/QIDP #2 stated that all staff had been trained on Resident #2's BSP. PD/QIDP #2 further stated that he would retrain on staff on Resident #2's BSP as soon as possible.

At the time of the survey, the GHIID failed to

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I 422	Continued From page 3 implement Resident #2's BSP, as recommended.	I 422	I 422 - Staff have been retrained on Client #2"s Behavior Support Plan (BSP). The facility's QIDP and House Manager will routinely support staff in implementing and adhering to Client #2's BSP interventions	07/15/19
			- Staff shall be retrained semi-annually or as needed on all BSPs.	07/15/19

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E 000 Initial Comments — E 000

An emergency preparedness survey was conducted from 06/19/19 through 06/20/19.

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

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

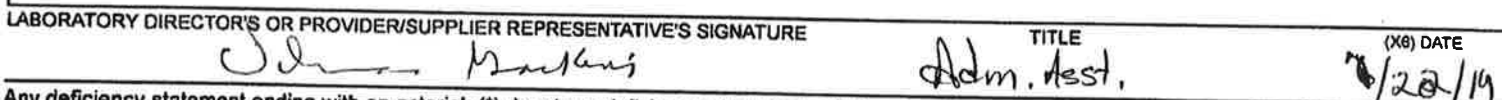
EP - Emergency Preparedness
EPP - Emergency Preparedness Plan
PD/QIDP - Program Director/Qualified Intellectual Disabilities Professional

E 026 Roles Under a Waiver Declared by Secretary
CFR(s): 483.475(b)(8) — E 026

[(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:]

(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm. Asst. — (X6) DATE: 6/22/19

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 026	Continued From page 1 waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by:	E 026	**E 026** - The facility will collaborate with external agencies in conducting a full scale exercise that is community based.	07/26/19
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. 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 a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated,	E 039	- Alternatively, the facility will document an individual facility based exercise if the facility experiences an actual natural or man-made disaster that requires activation of the Emergency Plan. This shall serve in the place of a community based exercise	07/15/19

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(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
E 039	Continued From page 2	E 039		

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 RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] 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 and 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.
This STANDARD is not met as evidenced by:
Based on record review and staff interview, the facility failed to document its efforts used to conduct a full-scale community-based exercise with outside sources, for four of four clients residing in the facility (Clients #1, 2, 3 and 4).

Findings included:

On 06/19/19 at 9:32 AM, the EP leader (PD/QIDP #2) agreed to make available for review all documentation pertaining to the facility's EPP on 06/20/19 by 9:00 AM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING ______ B. WING ______	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	[redacted] WASHINGTON, DC 20011

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E 039	Continued From page 3 On 06/20/19 beginning at 12:05 PM, review of the facility's EPP (updated 05/31/19) showed that the facility did not participate in a full-scale community-based exercise to present. At 12:54 PM, PD/QIDP #2 confirmed during an interview that he had not reached out to outside sources about coordinating a full-scale exercise with the facility. At the time of the survey, the facility failed to show evidence that it attempted to identify a full-scale community-based exercise.	E 039	**E 039** - The facility will collaborate with external agencies in conducting a full scale exercise that is community based.	07/26/19
			- Alternatively, the facility will document an individual facility based exercise if the facility experiences an actual natural or man-made disaster that requires activation of the Emergency Plan. This shall serve in the place of a community based exercise	07/15/19