DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/21/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 09G153 B. WING 08/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 000 INITIAL COMMENTS W 000W 000 The facility was in A recertification survey was conducted from substantial compliance 08/30/18 through 08/31/18. A sample of two with the requirements of clients was selected from a population of four males with varying degrees of intellectual 42 CFR 483, Subpart I, disabilities. This survey was conducted utilizing Requirements for the focused fundamental survey process. Intermediate Care Facilities. The findings of the survey were based on 08/31/18 observations, interviews and review of client and administrative records. No deficiencies were cited 08/31/18 The survey findings determined that the facility was in substantial compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities. No deficiencies were cited. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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 program participation.

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	A licensure survey we through 08/31/18. A selected from a pop various degrees of it. The findings of the subservations, interviand administrative realizable. The survey findings was in substantial correquirements of Title Medicine Chapter 35 Individuals with Intellideficiencies were cited.	vas conducted from 08/30/18 A sample of two residents was ulation of four males with intellectual disabilities. Survey were based on ews, and reviews of resident ecords. Idetermined that the facility impliance with the 22 Public Health and Group Homes for ectual Disabilities. No ed.	1000	The facility was in substantial compliance with the requirements Title 22 Public Health and Medicine Chapte Group Homes for Individuals with Intellectual Disabilities No deficiencies we cited	of her 35
TORY DIF	n & Licensing Administral RECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATI	URE	Adm. ASSI.	(X6) DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/21/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 09G153 B. WING NAME OF PROVIDER OR SUPPLIER 08/31/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 000 **Initial Comments** E 000 An emergency preparedness survey was conducted from 08/30/18 through 08/31/18. The findings of the survey were based on interviews and the review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. COOP/EP - Continuity of Operations Plan Manual/Emergency Preparedness Plan EP - Emergency Plan EPP - Emergency Preparedness Program QIDP - Qualified Intellectual Disabilities **Professional** Plan Based on All Hazards Risk Assessment E 006 E 006 CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk

*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

assessment, utilizing an all-hazards approach.*

*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

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

Adm. Ass

(X6) DATE

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 these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/21/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G153 B. WING NAME OF PROVIDER OR SUPPLIER 08/31/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II TON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (X5)(EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 006 Continued From page 1 E 006 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the EPP included strategies that addressed facility and community based disasters identified in the risk assessments, for four of four clients in the facility (Clients #1, 2, 3 and 4). E 006 The facility has updated it Findings included: **Emergency Preparedness** On 08/30/18, beginning at 3:22 PM, the QIDP Plan (EPP) to include stated that the facility was still developing strategies for addressing strategies for addressing the risk identified in the emergency events/disasters facility and community based risk assessment. identified in the facility On 08/31/18, beginning at 10:25 AM, review of and community based risk the facility's COOP/EPP dated November 2017 assessments. Please see confirmed the QIDP's interview that specific 09/20/18 herewith strategies for emergency events/disasters identified in the facility and community based risk Staff have been trained on assessment were not outlined in the COOP/EPP. the updated EPP. Staff will At the time of the survey, the facility failed to be trained annually or as ensure that the EP included strategies that needed on the updated addressed facility and community-based EPP. disasters identified in the risk assessment. 09/25/18

Local, State, Tribal Collaboration Process

E 009

E 009

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/21/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G153 B. WING NAME OF PROVIDER OR SUPPLIER 08/31/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II VASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) E 009 Continued From page 2 E 009 E 009 CFR(s): 483.475(a)(4) The facility has updated it Emergency Preparedness [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan Plan (EPP) to include that must be reviewed, and updated at least collaboration with local, annually. The plan must do the following:] regional, state, and federal EP officials to ensure (4) Include a process for cooperation and integrated response during collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts a disaster or emergency 09/20/18 to maintain an integrated response during a situation. disaster or emergency situation, including On July 13, 2018 the documentation of the facility's efforts to contact facility collaborated with such officials and, when applicable, of its DOH on regarding alert participation in collaborative and cooperative issued by the DC water and planning efforts. Sewer Authority 09/25/18 * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and On 09/13/18, the facility collaboration with local, tribal, regional, State, and collaborated with DC Federal emergency preparedness officials' efforts to maintain an integrated response during a Health Medical Coalition disaster or emergency situation, including (DCHMC) on preparedness documentation of the dialysis facility's efforts to for Hurricane Florence. contact such officials and, when applicable, of its participation in collaborative and cooperative 09/13/18 planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop written policies and procedures to ensure cooperation and collaboration with local, regional, state and federal EP officials efforts to ensure an integrated response during a

disaster, for four of four clients residing in the

facility (Clients #1, 2, 3 and 4).

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

PRINTED: 09/21/2018 FORM APPROVED OMB NO. 0938-0391

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	E 015	administrators had a regional, state and francipular an integrated responsive mergency situation. On 08/31/18, beginn the facility's COOP/Endergency situation of evidence that the local, regional, state ensure an integrated or emergency situation. Subsistence Needs of CFR(s): 483.475(b)(state) [(b) Policies and procedure policies and procedure plan set forth in paragrament at paragrament at paragrament and updated minimum, the policies and updated minimum, the policies address the following: (1) The provision of stand patients whether polace, include, but are in procedure in plance, include, but are in procedure in plance, include, but are in procedure in plance, include, but are in place, include, but are in place.	ning at 3:22 PM, the QIDP view that the facility's not contacted the local, rederal EP officials to ensure use during a disaster or an animal. In at 10:25 AM, review of EPP November 2017 showed facility collaborated with and federal EP officials to a response during a disaster on. For Staff and Patients 1) Cedures. [Facilities] must cent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be distinct a series of the section of	E 009			

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fi to a fc ()	safety and for the sa provisions. (B) Emergency lig (C) Fire detection systems. (D) Sewage and water in the policies and procedure (6) The following are hospice-operated in the policies and provision of shospice employees a evacuate or shelter in the policies. (B) Alternate source following: (II) Temperature and safety and for the policies. (B) Alternate source following: (1) Temperature and safety and for the policies. (2) Emergency light (3) Fire detections systems. (C) Sewage and water in the policies and safety and for the policies and water detections and wasted on record reviewed and wasted disposal) dispersions.	afe and sanitary storage of phting. A extinguishing, and alarm waste disposal. A dice at §418.113(b)(6)(iii):] A dice at §418.113(b)(iii):] A dice at §418.113(b)(iii):] A dice at §418.113(b)(ii	E 018			

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E 022	snowed no evidence included measures to disposal. During an interview of QIDP said during an to be updated to include for sewage and wasted and the facility's policity addressed all subsistivations. Policies/Procedures of CFR(s): 483.475(b)(4) (b) Policies and procedure plan set forth in paragrand the communication this section. The policity and the communication that section is section. The policity and the communication that section is section. The policity and the communication that section is section. The policity and the communication that section is section in paragrand the communication that section is section. The policity and the communication that section is section in paragrand the communication that section is section. The policity and the communication is section.	dated November 2017 that policies and procedures to address sewage and waste on 08/31/18 at 11:36 AM, the interview that the EP needed ude policies and procedures te disposal services. The vey, there was no evidence cies and procedures tence needs, such as isposal during emergency for Sheltering in Place The [facilities] must enterement the emergency preparedness tence, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of the cies and procedures must be died at least annually. At a and procedures must	E 022	The facility has updated Emergency Preparednes Plan (EPP) to include strategies for addressing subsistence needs such sewage and waste disposite updated EPP. Staff to be trained annually or as needed on the updated EPP.	g as osal on will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/21/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G153 B. WING NAME OF PROVIDER OR SUPPLIER 08/31/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 022 Continued From page 6 E 022 hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures that address a means of sheltering in place for clients and staff who remain in the facility during a disaster or emergency situations, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 08/30/18, beginning at 3:22 PM, review of the facility's COOP/EPP dated November 2017 showed no evidence that the facility had developed policies and procedures to address E 022 sheltering in place. The facility has updated it On 08/31/18, at 10:27 PM, the QIDP said during **Emergency Preparedness** an interview that staff had been trained on what to Plan (EPP) to include do should staff and clients have to shelter in strategies for addressing place for tornados, power outage, severe weather, hurricane, etc. When asked if there shelter in place during were policies and procedures outlined in the emergencies and disasters COOP/EPP for in sheltering place that was 09/20/18 aligned with the facility's risk assessment, the Staff have been trained on QIDP responded by saying, the policies and the updated EPP. Staff will procedures were in the development stages. be trained annually or as At the time of the survey, there was no evidence needed on the updated that the facility's developed policies and

E 033

procedures that the EP addressed sheltering in

place during emergencies and disasters.

Methods for Sharing Information

E 033

EPP.

09/25/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/21/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G153 B. WING. NAME OF PROVIDER OR SUPPLIER 08/31/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMP CARE II STINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) E 033 Continued From page 7 E 033 CFR(s): 483.475(c)(4)-(6) [(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 annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means

of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR

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E 035	Findings included: On 08/30/18, beginn facility's EP dated Not evidence of written pensure the confidential including the general clients during an emetal clients. The QII procedures would be At the time of the sun that the facility develothat addressed the regarding the general clients during an emetal clients during an emetal clients. The QII procedures would be At the time of the sun that the facility develothat addressed the regarding the general clients during an emetal clients during	inot met as evidenced by: view and interview, the facility itten policies and procedures means the facility would use rmation to include the general on of clients, for four of four e facility (Clients #1, 2, 3 and ing at 3:22 PM, review of the ovember 2017 showed no olicies and procedures to iality of client information, condition and location of ergency. Ing at 10:25 AM, the QIDP of the communication plan e client of information that, heral condition and location DP said that the policies and included in the updated EP. Inception of the information condition and location of regency. Ing Plan with Patients Ind ICF/IIDI must develop	E 035	The facility has updated Emergency Preparednes. Plan (EPP) to include policies and procedures release of information regarding health related issues, general condition and location of person during an emergency. Staff have been trained of the updated EPP. Staff we be trained annually or as needed on the updated EPP.	op/20/18

PRINTED: 09/21/2018

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

PRINTED: 09/21/2018 FORM APPROVED OMB NO. 0938-0391

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E 035	(8) A method for shemergency plan, the is appropriate, with families or represer This STANDARD is Based on record refailed to ensure each representative had regarding the facility four clients residing and 4). Findings included: On 08/30/18, beging facility's communicating with guardians were via On 08/31/18, beging during an interview clients' family membal telephone or e-mail current EP informat would e-mail the clients' facility. At the time of the suensure the clients' facility is appropriate to the suensure the clients' facility.	nually.] The communication II of the following: aring information from the at the facility has determined residents [or clients] and their statives. In not met as evidenced by: Eview and interview, the facility is client's family member or been given information y's emergency plan, for four of in the facility (Clients #1, 2, 3) Ining at 3:22 PM, review of the ation plan dated November rimary and alternate means for a family members and telephone and e-mails. Ining 10:25 AM, the QIDP said that he had not contacted the pers and/or guardians via regarding the facility's most ion. The QIDP stated that he ents' family members and y's EPP as soon as possible. Invey, the facility failed to amily members and/or de aware of the facility's EPP	E 034	E 035	The updated EPP and I have been reviewed withe person's family members and/or guard Please see evidence herewith. The facility will on an annual basis review the facility's EPP and PEP with the person's family and/or guardian.	ians. 09/15/18	