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

received 10/15/18

PRINTED: 09/21/2018
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 _____	08/31/2018

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 08/30/18 through 08/31/18. A sample of two clients was selected from a population of four males with varying degrees of intellectual disabilities. This survey was conducted utilizing the focused fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. 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.	W 000	**W 000** - The facility was in substantial compliance with the requirements of **42 CFR 483**, Subpart I, Requirements for Intermediate Care Facilities. - **No deficiencies were cited**	**08/31/18** **08/31/18**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm. Asst. (X6) DATE: 10/15/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0127	A. BUILDING: _____ B. WING _____	08/31/2018

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) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from 08/30/18 through 08/31/18. A sample of two residents was selected from a population of four males with various degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and reviews of resident and administrative records. The survey findings determined that the facility was in substantial compliance with the requirements of Title 22 Public Health and Medicine Chapter 35 Group Homes for Individuals with Intellectual Disabilities. No deficiencies were cited.	I 000	**I 000** - The facility was in substantial compliance with the requirements of **Title 22 Public Health and Medicine Chapter 35** Group Homes for Individuals with Intellectual Disabilities. - **No deficiencies were cited**	**08/31/18** **08/31/18**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Markins

TITLE: Adm. Asst.

(X6) DATE: 10/15/18

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 _____	08/31/2018

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
E 000	Initial Comments 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	E 000		
E 006	Plan Based on All Hazards Risk Assessment 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 assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Mackin | TITLE: Adm. Asst. | (X6) DATE: 10/15/18

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

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 _____	08/31/2018

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

(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 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on 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). Findings included: On 08/30/18, beginning at 3:22 PM, the QIDP stated that the facility was still developing strategies for addressing the risk identified in the facility and community based risk assessment. On 08/31/18, beginning at 10:25 AM, review of the facility's COOP/EPP dated November 2017 confirmed the QIDP's interview that specific strategies for emergency events/disasters identified in the facility and community based risk assessment were not outlined in the COOP/EPP. At the time of the survey, the facility failed to ensure that the EP included strategies that addressed facility and community-based disasters identified in the risk assessment.	E 006	E 006 - The facility has updated it Emergency Preparedness Plan (EPP) to include strategies for addressing emergency events/disasters identified in the facility and community based risk assessments. Please see herewith - Staff have been trained on the updated EPP. Staff will be trained annually or as needed on the updated EPP.	09/20/18 09/25/18
E 009	Local, State, Tribal Collaboration Process	E 009		

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 _____	08/31/2018

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
E 009	Continued From page 2 CFR(s): 483.475(a)(4) [(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:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative 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).	E 009	**E 009** - The facility has updated it Emergency Preparedness Plan (EPP) to include collaboration with local, regional, state, and federal EP officials to ensure integrated response during a disaster or emergency situation. **09/20/18** - On July 13, 2018 the facility collaborated with DOH on regarding alert issued by the DC water and Sewer Authority **09/25/18** - On **09/13/18**, the facility collaborated with DC Health Medical Coalition (DCHMC) on preparedness for Hurricane Florence. **09/13/18**	

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 _____	08/31/2018

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
E 009	Continued From page 3 Findings included: On 08/30/18, beginning at 3:22 PM, the QIDP said during an interview that the facility's administrators had not contacted the local, regional, state and federal EP officials to ensure an integrated response during a disaster or an emergency situation. On 08/31/18, beginning at 10:25 AM, review of the facility's COOP/EPP November 2017 showed no evidence that the facility collaborated with local, regional, state and federal EP officials to ensure an integrated response during a disaster or emergency situation.	E 009		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and	E 015		

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 _____	08/31/2018

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
E 015	Continued From page 4 safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies and procedures to ensure subsistence needs (specifically sewage and waste disposal) during 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	E 015		

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 _____	08/31/2018

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
E 015	Continued From page 5 facility's COOP/EP dated November 2017 showed no evidence that policies and procedures included measures to address sewage and waste disposal. During an interview on 08/31/18 at 11:36 AM, the QIDP said during an interview that the EP needed to be updated to include policies and procedures for sewage and waste disposal services. At the time of the survey, there was no evidence that the facility's policies and procedures addressed all subsistence needs, such as sewage and waste disposal during emergency situations.	E 015	**E 015** - The facility has updated it Emergency Preparedness Plan (EPP) to include strategies for addressing subsistence needs such as sewage and waste disposal - Staff have been trained on the updated EPP. Staff will be trained annually or as needed on the updated EPP.	**09/20/18** **09/25/18**
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(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:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for	E 022		

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 _____	08/31/2018

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
E 022	Continued From page 6 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 sheltering in place. On 08/31/18, at 10:27 PM, the QIDP said during an interview that staff had been trained on what to do should staff and clients have to shelter in place for tornados, power outage, severe weather, hurricane, etc. When asked if there were policies and procedures outlined in the COOP/EPP for in sheltering place that was aligned with the facility's risk assessment, the QIDP responded by saying, the policies and procedures were in the development stages. At the time of the survey, there was no evidence that the facility's developed policies and procedures that the EP addressed sheltering in place during emergencies and disasters.	E 022	E 022 - The facility has updated it Emergency Preparedness Plan (EPP) to include strategies for addressing shelter in place during emergencies and disasters - Staff have been trained on the updated EPP. Staff will be trained annually or as needed on the updated EPP.	09/20/18 09/25/18
E 033	Methods for Sharing Information	E 033		

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 _____	08/31/2018

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
E 033	Continued From page 7 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	E 033		

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 _____	08/31/2018

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
E 033	Continued From page 8 164.510(b)(4). This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies and procedures that addressed the means the facility would use to release client information to include the general condition and location of clients, 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 EP dated November 2017 showed no evidence of written policies and procedures to ensure the confidentiality of client information, including the general condition and location of clients during an emergency. On 08/31/18, beginning at 10:25 AM, the QIDP was asked about how the communication plan addressed the release client of information that, would include the general condition and location of the clients. The QIDP said that the policies and procedures would be included in the updated EP. At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed the release of information regarding the general condition and location of clients during an emergency.	E 033	**E 033** - The facility has updated it Emergency Preparedness Plan (EPP) to include policies and procedures for release of information regarding health related issues, general condition, and location of person during an emergency. - Staff have been trained on the updated EPP. Staff will be trained annually or as needed on the updated EPP.	09/20/18 09/25/18
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and	E 035		

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 _____	08/31/2018

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
E 035	Continued From page 9 updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client's family member or representative had been given information regarding the facility's emergency plan, for four 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 communication plan dated November 2017 showed the primary and alternate means for communicating with family members and guardians were via telephone and e-mails. On 08/31/18, beginning 10:25 AM, the QIDP said during an interview that he had not contacted the clients' family members and/or guardians via telephone or e-mail regarding the facility's most current EP information. The QIDP stated that he would e-mail the clients' family members and guardians the facility's EPP as soon as possible. At the time of the survey, the facility failed to ensure the clients' family members and/or guardians were made aware of the facility's EPP once the plan had been developed.	E 035	**E 035** - The updated EPP and PEPs have been reviewed with the person's family members and/or guardians. 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.	09/15/18 09/15/18