PRINTED: 04/26/2019
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
	09G056	A. BUILDING ______ B. WING ______	04/11/2019

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

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W 000	INITIAL COMMENTS A recertification survey was conducted from 04/09/19 to 04/11/19. A sample of three clients was selected from four men and one woman. 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: LPN - Licensed Practical Nurse MAR - Medication Administration Record PCP - Primary Care Physician POS - Physician's Order Sheets QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000		
W 368	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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client received all medications in accordance with the POS, for one of five clients residing in the facility (Client #3). Findings included:	W 368		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Johnna Mathis (signature)
TITLE: Adm. Asst.
(X6) DATE: 5/10/2019

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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W 368	Continued From page 1	W 368		

On 04/09/19 at 6:27 AM, the facility's LPN was observed reading from the pharmacy label on a blister pack while comparing the label with Client #3's April 2019 POS and MARs. The label said Client #3 was to receive two tablets of Vitamin D3, 1000 units each, equaling 2000 units total. The LPN and the surveyor noted there was only one tablet in each bubble. The LPN stated that she would "check with the pharmacy." She punched the one tablet (1000 units) from the blister pack and administered it and the other medications prepared for Client #3.

On 04/09/19 at 10:14 AM, review of Client #3's April 2019 POS and MAR confirmed the following order: "Vitamin D3 1000 unit tab. Take two tablets by mouth once a day."

On 04/09/19 at 10:17 AM, the LPN stated that she had administered Client #3's medications on the previous morning and during the previous week and had not noticed there was only one tablet in the blister pack instead of two. The LPN stated that she had notified the facility's RN, QIDP and the pharmacist on that morning. On 04/10/19 at 9:55 AM, the QIDP stated that the pharmacist had delivered a new blister pack on the previous evening and Client #3 received two tablets (2000 units) of Vitamin D3 that morning. In addition, staff had documented notifying the PCP of the error.

It should be noted that Client #3's April 2019 MARs showed that in addition to the LPN, three other facility staff had administered the Vitamin D3 tablet that month, with no evidence that anyone identified the error prior to the survey.

On 04/10/19 at 12:15 PM, the RN stated that

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W 368	Continued From page 2 routinely, the pharmacist delivers medications, POS and MARs towards the end of a month. The LPN reconciles the medications with the POS and MARs. The RN then does the same before the PCP signs the POS and MARs. The RN said henceforth, they will "examine each delivery closely." At the time of the survey, the facility failed to ensure that all of Client #3's medications were administered in accordance with the POS. This is a repeat deficiency. See Federal Deficiency Report dated 07/13/18.	W 368	**W 368** - The facility's Registered Nurse (RN) has trained all Licensed Practical Nurses (LPNs) and Trained Medication Employees (TMEs) on the rights of medication administration, adhering to Physician Orders (POSs) and drug count/reconciliation. Please see sign-in sheet and agenda for the training.	**05/03/19**
			- The facility's RN will on a monthly basis compare Physician's Orders with Medication Administration Records (MARs), and reconciliation of drugs to ensure that LPNs and TMEs are following orders as specified, and administering the specified amount of medicines. An LPN and/or a TME found not be in compliance will face corrective action.	**05/03/19**

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from 04/09/19 to 04/11/19. A sample of three residents was selected from four men and one woman. 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. CPR - Cardio Pulmonary Resuscitation DSP - Direct Support Professional GHIID - Group Home for Individuals with Intellectual Disabilities QIDP - Qualified Intellectual Disabilities Professional	I 000		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to ensure that all DSPs had current health certificates on file that were signed and dated by a physician, for three of ten DSPs reviewed (DSPs #1, 2 and 3). Findings included: On 04/09/19 beginning at 3:00 PM, review of the	I 206		

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm. Asst.	5/10/2019

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I 206	Continued From page 1 personnel records revealed there was no evidence of a physician's health inventory/certificate for DSPs #1, 2 and 3 who provided direct support to five of the five residents residing in the facility. When queried about the missing physician's health inventories on 04/09/19 at approximately 4:30 PM, the QIDP indicated that he would request the aforementioned health certificates. No additional information was made available for review before the survey ended on 04/11/19.	I 206	**I 206** - DSPs #1, 2, and 3 have completed their physicals. Please see attached.	05/03/19
			- At the beginning of each month, the facility's Quality Assurance (QA) staff will conduct audit of all personnel records to determine whose health certificate and/or CPR and First Aid will be expiring within thirty (30) days. Employees will be informed by written notification to update their personnel records. A staff who fails to comply with such request, will be taken off the schedule until he or she submit the requested document (s)	05/03/19
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the GHIID failed to have on file for review, evidence of current certification in CPR, for one of ten DSPs reviewed (DSP #3). Findings included: Review of the personnel records on 04/09/19 beginning at 3:00 PM, revealed no evidence of a current CPR certification for DSP #3. When queried about the expired CPR card on 04/09/19 at approximately 4:30 PM, the QIDP indicated that he would request the	I 227		

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I 227	Continued From page 2 aforementioned CPR certificate from the main office. No additional information was made available for review before the survey ended on 04/11/19.	I 227	**I 227** - DSP #3 has submitted a current CPR card. Please see attached.	05/03/19
			- At the beginning of each month, the facility's Quality Assurance (QA) staff will conduct audit of all personnel records to determine whose CPR and First Aid will be expiring within thirty (30) days. Employees will be informed by written notification to update their personnel records. A staff who fails to comply with such request, will be taken off the schedule until he or she submit the requested document (s)	05/03/19

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E 000	Initial Comments An emergency preparedness survey was conducted from 04/09/19 through 04/11/19. 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. BSP - Behavior Support Plan CP - Communication Plan DPS - Day Program Staff DSP - Direct Support Professional EP - Emergency Plan EPP - Emergency Preparedness Program HM - House Manager PEPP - Personal Emergency Preparedness Plan QIDP - Qualified Intellectual Disabilities Professional	E 000		
E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(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:] (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.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC,	E 007		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm. Asst. (X6) DATE: 5/10/2019

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E 007	Continued From page 1	E 007		

FQHC, or ESRD facilities.]
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility's emergency plan failed to address the most vulnerable client at risk, for one of five clients residing in the facility (Client #1).

Findings included:

Observations at the day program on 04/09/19 beginning at 11:38 AM, revealed the day program staff (DPS #1) tried to sanitize Client #1's hands, but the client yelled and tried to hit the staff. At 11:47 AM, DPS #1 tried to assist Client #1 to the table for lunch but the client yelled and tried to hit the staff again.

On 04/10/19 at 9:47 AM, review of Client #1's BSP, dated 10/15/18, revealed the client had three target behaviors: physical aggression, self-injurious behaviors, and "removal of clothing in public places or outside of normal routine care."

On 04/10/19, beginning at 2:58 PM, review of the EP, updated 01/01/19, and Client #1's PEPP, dated 03/19/19, revealed the plans failed to address the aforementioned target behaviors for Client #1. The client's PEPP mentioned the removal of clothing; however, it did not provide written guidance or a plan regarding how facility staff or others should assist the client.

During an interview on 04/10/19 at 3:45 PM, the QIDP stated that Client #1's BSP would accompany the client, and that staff had all received training on the BSP. Earlier review of the EPP and PEPP, however, failed to show instruction to bring the client's BSP when they

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E 007	Continued From page 2 evacuate the facility. In a follow-up interview on 04/11/19 at 10:47 AM, the QIDP stated they had determined that Client #1 was the client deemed most "at risk" during an emergency. He cited the client's impaired vision and need for assistance while ambulating. The QIDP then reviewed the EPP and PEPP and acknowledged that neither document outlined a plan for addressing the client's assessed physical and behavioral needs. At the time of the survey, the facility failed to ensure that the EPP and/or Client #1's PEPP included plans to address the client's assessed behavioral and physical needs to ensure the client's health and safety during and after an emergency evacuation.	E 007	**E 007** - Client #1's PEPP and the facility's EPP have been updated to include instructions to have BSPs placed in the emergency bags for all clients with BSPs. The addendum section of the EPP (page 35) states that a person's BSP shall be part of the documents needed during emergency evacuation. Please see addendum page of the facility's EPP.	05/03/19
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(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:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b),	E 018	- Client#1's PEPP has been revised to include all targeted behaviors and instruction included to bring along the BSP during emergency evacuation.	05/03/19

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E 018	Continued From page 3	E 018		

ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical

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E 018	Continued From page 4	E 018		

documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to develop written policies and procedures to track the location of staff and clients during an emergency, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5).

Findings included:

1. On 04/10/19 beginning at 12:40 PM, review of the facility's EP (updated 01/01/19) revealed no written guidance as to how the locations of clients and staff would be tracked and documented during and after an emergency.

On 04/10/19 at 4:02 PM, the QIDP stated that facility staff were to use "Tracking Oversight Forms" and "Disaster Drill Forms" to document emergency drill events and actual emergencies. He then acknowledged that there were no written policies and procedures regarding how staff were to use the two forms and keep administrators informed of the location of each on-duty staff and client.

2. On 04/10/19 at 2:06 PM, review of recently-used "Tracking Oversight Forms" revealed the forms did not designate a space or area where staff were to document the location of on-duty staff and clients.

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E 018	Continued From page 5	E 018		

On 04/10/19 at 3:55 PM, the QIDP stated that the location of on-duty staff and clients will be documented on a "Disaster Drill Form." He presented a "Disaster Drill Form," dated 03/19/19, on which staff documented having evacuated the five clients to an address on Chillum Place, NW. There was no name given for the facility at the Chillum Place address. The QIDP stated that the address given was that of a day program that was owned by the same governing body. Similarly, a "Disaster Drill Form" dated 12/08/18 showed the on-duty staff and clients had relocated to an address on New Hampshire Avenue; there was no name given for that address. The QIDP stated that the address was that of the agency's corporate offices. He then acknowledged that staff had not documented the specific name of the two locations to where they and clients had relocated during the drills.

3. On 04/10/19 beginning at 2:06 PM, review of the "Tracking Oversight Form" revealed the following instruction at the bottom of the form: "This form is to be completed by the QIDP or managerial staff every two hours during emergency. This includes full scale drills." Review of the "Tracking Oversight Forms" completed during the two most recent emergency drills revealed the following:

- 03/19/19 8:05 PM, completed at 7:30 PM by the HM;
- 03/19/19 8:05 PM, completed at 10:30 PM by DSP #9;
- 03/19/19 8:05 PM, completed at 10:30 PM by DSP #10;
- 02/06/19 12:00 PM, completed at 1:00 PM by DSP #6; and,

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E 018	Continued From page 6 - 02/06/19 12:00 PM, completed at 2:00 PM by DSP #8 Of the five aforementioned forms, one was completed by managerial staff and the other four forms were completed by DSPs. On 04/11/19 at approximately 11:50 AM, the QIDP was asked to further clarify how and when the "Tracking Oversight Forms" should be used. He explained that at two-hour intervals during a drill event, staff will take a head count, complete a "Tracking Oversight Form" and submit the form to "the lead." He then stated that the facility will develop written policies and procedures that outline a tracking system for documenting the locations of all clients and on-duty staff. At the time of the survey, the facility failed to establish a means of tracking the location of all on-duty staff and clients during and after emergencies, including the name of other locations where staff and clients have been relocated during the emergency. This is a repeat deficiency. See Federal Deficiency Report dated 07/13/18.	E 018	**E 018** - (1) The facility's EPP has been updated to include how staff will keep administrators informed of the location of each on-duty staff and clients. - (2) The tracking oversight form has been revised to include location of on-duty staff and clients during emergency evacuation.	05/03/19 05/03/19
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(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	E 026		

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	09G056	A. BUILDING ______ B. WING ______	04/11/2019

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

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E 026	Continued From page 7	E 026		

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 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:
Based on interview and record review, the facility failed to develop policies and procedures that describe its role in providing care during major disasters or federal emergencies, for five of five clients residing in the facility (Clients #1, 2, 3, 4, and 5).

Findings included:

On 04/10/19, beginning at 12:44 PM, review of the facility's EPP, dated 01/01/19, failed to show evidence that the facility had developed policies and procedures to address the role of the facility under a waiver declared by the Secretary of Health and Human Services (public health emergencies) or in the provision of care and treatment at an alternate care site identified by emergency management officials when the President of the United States, in accordance with section 1135 of the Stafford Act, declares a major disaster or emergency.

During an interview on 04/11/19 beginning at

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E 026	Continued From page 8 11:25 AM, the QIDP, who was also the emergency preparedness leader, confirmed that there was no policy currently in place regarding the 1135 waiver. He said the agency was in the process of developing policies and procedures for the 1135 waiver. At the time of the survey, there was no evidence that the facility's EPP addressed the provision of care at alternate sites during national emergencies.	E 026	**E 026** - The facility has developed procedures pertaining to the role of staff in the provision of care and treatment at alternative sites during emergencies. Please see addendum page of the facility's EPP.	**05/03/19**
E 034	Information on Occupancy/Needs CFR(s): 483.475(c)(7) [(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: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or	E 034		

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E 034	Continued From page 9 designee. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies that addressed the means by which the facility would provide information about its occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, for five of five clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included: On 04/10/19 beginning at 1:40 PM, review of the facility's CP, updated 01/01/19, revealed no written guidance or instructions regarding how the facility would share with the authority having jurisdiction the facility's occupancy, needs, and its ability to provide assistance during an emergency. On 04/11/19 at 12:27 PM, the QIDP wrote some notes, looked in the EPP briefly and then stated "OK." At the time of the survey, there was no evidence that the facility's CP addressed the method the facility would use to convey to the authority having jurisdiction its occupancy, its needs, and/or its ability to provide assistance during an emergency.	E 034	**E 034** - The facility has updated its Communication Plan to include means of providing information about its occupancy, needs, and ability to provide assistance to the authority having jurisdiction. Please see attached.	05/03/19
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at	E 036		

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paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to develop and maintain an emergency preparedness training and testing program based on the risk assessment, policies and procedures and the communication plan, for five of five clients residing in the facility (Clients #1, 2, 3, 4,

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and 5).

Findings included:

On 04/10/19 beginning at 12:58 PM, review of the facility's EPP, updated 01/01/19, revealed no evidence that the facility had established written policies and procedures regarding a training and testing program. The risk assessment showed snow falls, blizzards, electrical failure, internal flood, extreme heat events and communications failures were among the highest risks for the facility. There were instructions on how to respond to such events and staff had documented several evacuation drills; however, there was no discernable testing and training program.

On 04/11/19 at 12:30 PM, the QIDP acknowledged that the facility had not developed a written training and testing program. He then stated that they would develop a program that states who, when, how, etc. the facility staff would conduct full-scale drills, table top activities and what was expected regarding the after activity analysis and reports. He added that once formalized, the testing and training program would be dated and reflect annual and periodic updates, as indicated.

At the time of the survey, the facility failed to establish and maintain a verifiable emergency preparedness training and testing program.

Plan of Correction	Completion Date
E 036 - The facility is in the process of completing a training and testing program. Such training and testing program shall be reviewed and updated at least annually. Staff will be trained quarterly on the training and testing program	**05/15/19**