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 _____ Received 8/22/18	07/13/2018

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 07/11/18 through 07/13/18. 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 DSP - Direct Support Professional EP - Emergency Plan EPP - Emergency Preparedness Program QIDP - Qualified Intellectual Disabilities Professional RC - Residential Coordinator	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	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm. Asst. (X6) DATE: 8/22/18

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.

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E 006	Continued From page 1 community-based risk assessment, utilizing an all-hazards approach, including missing clients. (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 five (5) of 5 clients in the facility (Clients #1, 2, 3, 4, and 5). Findings included: On 07/13/18, at 10:10 AM, the Administrative Assistant and QIDP said that the agency began developing a comprehensive emergency plan in November of 2017. The QIDP stated that the strategies for addressing emergency events/disasters in the facility and community based risk assessment were not outlined in the COOP/EPP. On 07/13/18, at 10:27 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.	E 006	**E 006** - The facility is working on updating strategies for addressing emergency events/disasters in the community. Such updates will be incorporated in the facility's Continuity of Operations Plan (COOP) and Emergency Preparedness Plan (EPP). - Staff will be trained on the updated strategies for addressing emergency events/disasters. The facility's QIDP will train staff quarterly on the updated strategies.	09/06/18 09/06/18

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E 006	Continued From page 2 At the time of the survey, the facility failed to ensure that the EPP included strategies that addressed facility and community-based disasters identified in the risk assessment.	E 006		
E 009	Local, State, Tribal Collaboration Process 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	E 009	**E 009** - The facility is working on developing policies and procedures incorporating collaboration with local, regional, state and federal Emergency Plan (EP) officials to ensure an integrated response during a disaster. Staff will be trained on the updated policies and procedures. The facility's QIDP will be training staff quarterly on the updated policies and procedures. - Policies and procedures developed on collaboration with local, regional, state and federal Emergency Plan (EP) officials will be incorporated in the facility's COOP/EPP.	09/06/18 09/06/18

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E 009	Continued From page 3 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 five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included: On 07/13/18, at 10:10 AM, 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 07/13/18, at 10:27 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. At the time of the survey, there was no evidence that the facility developed policies and procedures that ensured cooperation and collaboration with local, regional, state and federal EP officials' efforts to ensure an integrated response during a disaster and/or emergency.	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	E 015		

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E 015	Continued From page 4	E 015		

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 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.

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E 015	Continued From page 5 (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop written policies and procedures that addressed subsistence needs, including food, alternative light sources, water, pharmaceutical supplies and sewage for clients and staff during emergency situations, for five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included: On 07/13/18, at 10:10 AM, the Administrative Assistant and QIDP indicated that the agency began developing a comprehensive emergency plan in November of 2017, as required. The QIDP indicated that the strategies for addressing food, water, pharmaceutical supplies, and sewage for clients and staff during emergency situations was documented in the COOP/EPP. On 07/13/18, at 10:27 AM, review of the facility's COOP/EPP November 2017 did not outline specific strategies for subsistence needs, including water, pharmaceutical supplies, and sewage. While the COOP/EPP reference the seven day supply of food would be in the facility. The plan did not specify how food would be provided if relocation to an alternative site was necessary. The plan did not address other subsistence needs such as alternative light sources, water, pharmaceutical supplies and sewage. On 07/13/18, at 11:05 AM, the QIDP and the Administrative Assistant confirmed that the	E 015	**E 015** - The facility is working on developing policies and procedures addressing: provision of subsistence needs for staff and patients whether they evacuate or shelter in place, alternate sources of energy to maintain temperatures to protect patient health and safety, safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, and alarm systems, and sewage and waste disposal. Staff will be trained on the above-policies and procedures. Policies and procedures addressing the aforesaid will be incorporated in the facility's COOP/EPP. The plan will address how food will be provided when residents and staff relocate to an alternative site.	09/06/18 09/06/18

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E 015	Continued From page 6 COOP/EPP had not considered specific strategies as it pertains to the above mentioned COOP/EPP requirements. However, a generic plan had been completed and a specific plan would be developed. At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed subsistence needs, including water, pharmaceutical supplies, and sewage during emergency situations.	E 015		
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), 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	E 018		

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E 018	Continued From page 7	E 018		

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

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E 018	Continued From page 8 *[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 policies and procedures to track the location of staff and sheltered clients during an emergency, for five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included: On 07/12/18, at 12:52 PM, DSP #1 was asked about the facility's method for tracking the location(s) of staff and sheltered clients during an evacuation. DSP #1 said facility staff would take a head count. DSP #1 stated that if the clients had to evacuate the facility, they would relocate to a hotel and/or Brooklyn Senior day services, call management staff and let them know where they were sheltering in place. At 11:33 AM, DSP #2 was asked about the facility's method for tracking the location(s) of staff and sheltered clients during an evacuation. DSP #2 stated that a head count would be taken and that she would call management (i.e. RC, QIDP) to let them know there location should they have to evaluate from the facility. On 7/13/18, beginning at 10:10 AM, the QIDP said during an interview that there was no policy on tracking staff or clients. The QIDP said that the policy and procedure for locating staff and clients to include sheltering in place and evacuation during an emergency needed to be added to the COOP/EPP. On 07/13/18, beginning at 10:27 AM, review of	E 018	E 018 - The facility is working on developing policies and procedures on tracking the location of staff and sheltered clients during an emergency. Staff will be trained on the completed policies and procedures. - A family communication plan (family herein referred to as the facility) will be instituted in guiding staff on how to efficiently communicate with the receiving facility or other location. - The policies and procedures on tracking the location of staff and sheltered clients during an emergency will be incorporated to the facility's COOP/EPP. Staff will be trained on the developed communication plan.	09/06/18 09/06/18 09/06/18

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E 018	Continued From page 9 the COOP/EPP dated November 2017 failed to show evidence that the facility had developed policies and procedures to address the ongoing tracking of sheltered clients and staff locations during and after an emergency. At the time of the survey, the facility failed to document a means of tracking the location of all staff and sheltered clients during and after emergencies.	E 018		
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 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.	E 022		

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E 022	Continued From page 10 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 five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4 and 5). Findings included: On 07/13/18, beginning at 10:27 AM, 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 for clients and staff. On 07/13/18, at 12:33 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/EEP for in sheltering place that was aligned with the facility's risk assessment, the QIDP responded by saying, the policies and procedures needed to be developed. 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's COOP/EPP/EP will be updated to address sheltering in place for clients and staff during an emergency. Staff will be trained on the updated COOP/EPP/EP with emphasis on sheltering in place.	**09/06/18**
E 029	Development of Communication Plan CFR(s): 483.475(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 029		

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E 029	Continued From page 11 and 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 a written communication plan in the facility's COOP/EPP, for five (5) of 5 clients residing in the facility (Clients #1, 2, 3, 4, and 5). Findings included: On 07/11/18, beginning at 8:30 AM, the QIDP said during the initial interview that the COOP/EPP did not include a formal communication plan. The QIDP stated that staff would communicate with administrators via telephone and/or email if there was an emergency. On 07/13/18, at 10:27 AM, review of the facility's COOP/EPP November 2017 confirmed the QIDP's interview that there was no formal communication plan included in the COOP/EPP. The COOP/EPP did however, include a few communication-related statements, policies and telephone numbers. The QIDP stated that the plan would be updated to reflect a communication plan. At the time of the survey, there was no evidence that the facility's outlined a communication plan in their COOP/EPP.	E 029	E 029 - The facility is working on updating the COOP/EPP to include comprehensive a communication plan. - The facility's QIDP will train staff on the updated communication plan.	09/06/18 09/06/18

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from 07/11/18 through 07/13/18. A sample of three residents was selected from a population of four men and one woman with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews and review 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	**TTITLE 22 CHAPTER 35:** - **THE FACILITY MET THE REQUIREMENTS Of TITLE 22, CHAPTER 35.**	**07/13/18**

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Delmus Mackins | TITLE: Adm. Asst. | (X6) DATE: 8/22/18

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 _____	07/13/2018

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	W 000		

A recertification survey was conducted from 07/11/18 through 07/13/18. A sample of three clients was selected from a population of four men and one woman 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.

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

LPN - Licensed Practical Nurse
POS - Physician's Orders
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse

W 368 DRUG ADMINISTRATION
CFR(s): 483.460(k)(1) — W 368

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 two (2) of three (3) clients in the core sample (Clients #1 and 3).

Findings included:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Johnnie Mathis	Adm. Asst.	8/22/18

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.

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W 368	Continued From page 1	W 368		

On 07/11/18, at 6:46 AM, morning observation showed Client #3 just completed breakfast which consisted of waffles, turkey sausage and a beverage. At 6:56 AM, Client #1 was observed to take his plate to the kitchen sink after completing breakfast. At 7:00 AM, the morning nurse arrived to the facility.

At 7:07 AM, observations of the medication administration pass showed the LPN administered Client #1 several different medications. The LPN said that Client #1 had one additional medication (Synthroid) that he took thirty (30) minutes after eating breakfast. The LPN then added that Client #3 also received Synthroid that was to be given 30 minutes after eating. Continued observations at 8:00 AM showed Client #1 received Synthroid 75 mg by mouth and at 8:02 AM, Client #3 was administered Synthroid 100 mg mixed with applesauce.

On 07/12/18, at 10:48 AM and 10:52 AM respectively, review of Clients #1 and #3 current POS both dated June 2018 showed that Synthroid should be administered 30 minutes before meals/2 hours after meals for hypothyroidism.

On 07/12/18, at 11:23 AM, the LPN was interviewed regarding the administration of Synthroid during the morning medication pass via, telephone. The LPN said that on 07/11/18, during the morning medication pass that he meant to say that Synthroid should be given 30 minutes prior to eating versus 30 minutes after eating. The LPN stated that he arrived to work later than usual and that it was his fault for administering the Synthroid medication at 8:00

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W 368	Continued From page 2 AM and 8:02 AM. The LPN further stated that he should have the morning 8:00 AM - 4:00 PM LPN and/or the QIDP/LPN to administer the medications to the clients after he missed the opportunity to administer the medications 30 minutes prior to their breakfast meals. On 07/13/18, at 2:47 PM, the surveyor shared with the RN that Clients #1 and #3 received their morning medication (Synthroid) at 8:00 AM and 8:02 AM when the medications should have been given 30 minutes prior to eating breakfast or 2 hours after breakfast. The RN said that the clients' medications should have been given 2 hours after the LPN missed the 30 minute window of administering the medications prior to breakfast. The RN stated that he would re-train all nurses as soon as possible on medication administration for all clients residing in the facility. At the time of the survey, the facility failed to ensure Clients #1 and 2 medications were administered in accordance with the POS.	W 368	**W 368** - The facility's Registered Nurse (RN) has trained all Licensed Practical Nurses (LPNs) and The Trained Medication Employee (TME) on the ten rights of medication administration. Please see sign-in sheet and agenda for the training. **07/20/18** - TMEs and LPNs will be observed quarterly on implementation of medication administration guidelines. **08/31/18**	