Received 2/19/19 15

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

PRINTED: 02/05/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G071	B. WING		01/11/2019	
	PROVIDER OR SUPPLIER  OR RESEARCH ASSO	CIATES		STREET ADDRESS, CITY, STATE, ZIP CODE		
BLIIA	JR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETI	
W 000	INITIAL COMMENT	-s	W 000			
	01/09/19 to 01/11/1 was selected from t	vey was conducted from 9. A sample of three clients ive males. The survey was the focus fundamental survey				
	The findings of the sobservations, interval administrative recor					
	The following abbre throughout the repo					
	DSP - Direct Suppo IPP - Individual Prog LPN - Licensed Pra QIDP - Qualified Inte Professional F - Farenheit	gram Plan ctical Nurse		-		
W 120		DED WITH OUTSIDE	W 120	Staff members were not instructed wash dishes in the basement and not told that common areas upstai	were	
	The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facilty failed to ensure outside services failed to ensure that each staff maintained infection control procedures, for one of three clients in the sample (Client #3).			were just for residential services. Common areas are used by the day program service during the day inc the living room, dining room, bathr	ay cluding	
				and kitchen. Staff providing that feedback received appropriate disciplinary actions2-4-19	Come	
	Findings included:					
	On 01/09/19, at 12:0	5 PM, Client #1 was				

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.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG			E SURVEY PLETED
					-		
		09G071	B. WING			01/	11/2019
	PROVIDER OR SUPPLIER DR RESEARCH ASSO	CIATER		STREET ADDRESS, CITY, S	TATE, ZIP CODE		
DETIATIO				WASHINGTON, DC 20	019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPR FICIENCY)	BE	(X5) COMPLETION DATE
W 125	Client #1 completed staff (DSP #1) assis while holding his discame out the bathroobservation reveale washed in the bathroobservation DSP at the client's dishes in soap. Further interving not use the kitchen in the day program.  At the time of the sure to ensure that each control procedures to infection.  PROTECTION OF (CFR(s): 483.420(a)(CFR(s): 4	program eating lunch. After I his lunch, the one to one sted the client to the bathroom shes. Moments later, DSP #1 from with Client #1. Continued the client's dishes were doom.  Toximately 12:10 PM, #1 revealed that he washed the bathroom with hand lew revealed that staff does that was located upstairs from the washed at the bathroom with hand lew revealed that staff does that was located upstairs from the washed at the bathroom with hand lew revealed that staff does that was located upstairs from the washed lew revealed that staff does that was located upstairs from the washed lew revealed that staff does that was located upstairs from the washed lew revealed that staff does that was located upstairs from the washed lied to allow and encourage exercise their rights as clients as citizens of the United States, file complaints, and the right on, interview and record lied to allow each client to egarding eating breakfast and lates, for one of five clients in	W 1	All staff will be retreated home space for proper infection contemphasis on proper 19. Additionally, the Dobserve lunch measure weekly to ensure to implemented included an activities.	or day services a control procedures er dishwashing ay Program QID als at minimum to hat they are propertions set up and	ind on s s with 2-20- P will wice	
	Observation on 01/0	9/19 at 6:58 PM, revealed					1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		09G071	B. WING		01/	11/2019
	PROVIDER OR SUPPLIER  OR RESEARCH ASSO	CIATES		STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE	(X5) COMPLETION DATE
W 125	Clients #2, 3, 4 and for dinner. During the bedroom with his or When asked, DSP after everyone has after everyone has after everyone has a PM, once Client #2, meal, DSP #1 assis room table for dinner 6:50 AM revealed Collent #2, 3, 4, and 90 On 01/10/19 at 1:16 revealed that Client other clients. The Q #1 has a goal to red	5 sat at the dining room table his time, Client #1 stayed in his he to one staff (DSP #1). #1 stated that Client #1 will eat finished their meal. At 7:32 3, 4 and 5 completed their ted Client #1 to the dining er. Observation on 01/10/19 at lient #1 ate breakfast after	W 1	The staff member in question recappropriate disciplinary follow upfailing to follow proper procedure assisting Client #1 during the meawas retrained on the prescribed procedures2-5-19  The QIDP will re-train all staff to econsistency2-10-19  The QIDP and Home Manager with observe meals on each shift (sepat minimum once weekly to ensure ongoing compliance and provide spot feedback and training if issue observed during the planned observations2-20-19	for in al and ensure III arately) re on-the-	
	Client #1's IPP, date revealed an objective mealtime, <client's #1="" 483.420(a)()="" and="" at="" breathousemates.="" care="" client="" cofr(s):="" daily="" eat="" ensor="" facility="" for="" grabbing="" mealtime="" must="" of="" of<="" others="" protection="" reof="" six="" sur="" surface="" th="" the="" therefore,="" time="" to="" treatment=""><th>7) ure the rights of all clients.  must ensure privacy during</th><th>W 13</th><th>30</th><th></th><th></th></client's>	7) ure the rights of all clients.  must ensure privacy during	W 13	30		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		09G071	B. WING		01/	/11/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		71112010
BEHAVI	OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE	(X5) COMPLETION DATE
W 130	client's used the bat residing in the facilit residing in the facilit Finding included:  On 01/10/19, at 7:13 sitting on the toilet was pants were observed and buttocks. During staff (DSP #3) was set the linen closet, which bathroom. During the linen clients were observed and clients were observed by the linen closet, which bathroom. During the linen clients were observed by the linen clients were observed by the line clients were observed by t	ailed to ensure privacy while throom, for one of five clients by (Client #3).  7 AM, Client #3 was observed with the door wide opened. His d down, exposing his legs g this time, the one to one sorting through linens from the was located next to the e aforementioned times, staff served within close proximity.  #3 on 01/10/19, at AM, revealed that the ld have been closed to	W	The staff member in question recappropriate disciplinary action fo to respect the privacy of Client # 19 All staff members were re-trained privacy and dignity with specific privacy during personal care and intimate self care tasks2-4-19 The QIDP and Home Manager (separately) will conduct observed during all shifts at minimum once to ensure consistency in follow u will receive immediate feedback issues are observed2-20-19	failure 32-4- I on ocus on tions weekly o; staff	
	Review of the privace 2:30 PM, revealed "I privacy during habilit needs."  At the time of the surensure Client #3's rigcare. INDIVIDUAL PROGREFR(s): 483.440(c)(6) The individual progra opportunities for client self-management. This STANDARD is Based on observation interview, facility staff	y protocol on 01/10/19, at Residents are afforded ation and care of personal  rvey, the facility failed to ght to privacy during personal  RAM PLAN 6)(vi)  am plan must include	W 2	47		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		09G071	B. WING_		01/	11/2019
	PROVIDER OR SUPPLIER  OR RESEARCH ASSO	CIATES		STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 247	three clients in the state of the clients in the client was sknow how to eat with the clients in the client was sknow how to eat with the client was sknow how to eat with the clients in the clients in the client was sknow how to eat with the clients in the	•	W 24	The staff member in question rece appropriate disciplinary action for to support Client #1 to eat with his and for failure to implement his mobjective to improve his skills in eindependently with others2-4-19 All staff members were retrained of measurable objective and on the importance of Client #1 developin the social skills and the eating skineeded to eat out and among others2-4-19	failure s peers easure ating 9. on the	
W 249	occupational therap showed Client #1 is hand over hand at ti At the time of the suto allow Client #1 to during each meal to capabilities.  PROGRAM IMPLEM CFR(s): 483.440(d)(d) As soon as the interformulated a client's each client must reconstruct treatment program of interventions and seand frequency to sur	y assessment dated 06/14/18 willing to participate with mes during meals.  Irvey, the facility's staff failed exercise his independence the full extent of his  MENTATION  (1)  disciplinary team has individual program plan, seive a continuous active	W 249			

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CLIVIL	NO FOR WEDICARE	& WEDICAID SERVICES		0	WR NO	. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		09G071	B. WING		01/	11/2019
NAME OF	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE		
BEHAVIO	OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Based on record re interview the facility client's recommende for one of three clier Findings included:  On 01/09/19, at 11:2 IPP, dated 06/2018 objective that stated name > will reduce i food while at the tab six consecutive mon Observation on 01/0 Clients #2, 3, 4 and for dinner. During this bedroom with his one When asked, DSP # after everyone has fi once Client #2, 3, 4 and SDSP #1 assisted Client #2, 3, 4, and 5.  On 01/10/19 at 1:16 revealed that Client #4.	s not met as evidenced by: view, observation, and failed to implement each ed active treatment program, nts in the sample (Client #1).  25 AM, review of Client #1's to 06/2019, revealed an , "During mealtime, <client's daily="" during="" for<="" grabbing="" le="" mealtime="" ncidents="" of="" others="" th=""><th>W 249</th><th></th><th>failure peers easure ating ). on the</th><th></th></client's>	W 249		failure peers easure ating ). on the	
(		ice incidents of grabbing the e, the client was required to				

At the time of the survey, facility staff failed to

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES		0	MB NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY IPLETED
		09G071	B. WING		01/	11/2019
NAME OF	PROVIDER OR SUPPLIER	-11		STREET ADDRESS, CITY, STATE, ZIP CODE		
BEHAVI	OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	Continued From pa	age 6	W 249			
		1's to mealtime IPP objective.				
W 426	CLIENT BATHROO		W 426	5		
	CFR(s): 483.470(d)	)(3)		The water temperature was lowere	ed to	
		areas of the facility where		110 degrees during the survey		
		ot been trained to regulate		process2-1-19 Staff members were retrained to c	heck	
		are exposed to hot water, perature of the water does not		water temperature daily and recor		1
	exceed 110 degree			temperature obtained. If that temp		
				is above 110 degrees, staff members were instructed to contact the Hon		
	This STANDARD is	s not met as evidenced by:		Manager for immediate follow up		
	Based on observat	tion and interview, the facility		19		
		t the water temperature did for five of five residents		The Home Manager checked the	201150	
		ty (Client #1, 2, 3, 4, and 5).		thermometers for each home to enall were working properly (they are 19		
	Findings included:			10		
		nental inspection on 01/11/19,				
		rom the faucet of the kitchen ch. When measured, the water				
		etermined to be 115°F.				
	Continued inspection	on of the first floor and second				
		rooms also revealed hot did 110°F as evidenced by the			-	
	following:	1 110 1 as evidenced by the				
	Kitchen faucet - 115	°F				
	First floor bathroom					
	Basement bathroon	1 - 114°F				
	On 01/11/19 the QI	OP was interviewed at 1:38				
	PM, concerning the	hot water temperatures. The				
		that the water was hot and red temperature of 110°F.				
		DP, two of five residents				
		have adaptive and cognitive				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G071	B. WING			01/1	11/2019
	PROVIDER OR SUPPLIER  OR RESEARCH ASSO	OCIATES		STREET ADDRESS, CITY, STATE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD I TO THE APPROPR	BE	(X5) COMPLETION DATE
W 454	Upon immediate not temperature on 01/1 the maintenance entemperatures. The indicated that the with turned down to achieve the contemperature again.  On 01/11/19, at 2:10 maintenance employ temperatures again. Kitchen faucet - 110 First floor bathroom Basement bathroom Basement bathroom Basement bathroom Basement bathroom CFR(s): 483.470(l)(). The facility must protect avoid sources and This STANDARD is Based on observation of the need of the contemperature and potential transmedication administ residing in the home. Findings included:	or water temperatures.  Detification of the hot water 11/19, the QIDP reported to imployee to check the water maintenance employee rater temperature would be reverted to environment to avoid sources institute and the surveyor and the revealed the following:  Description of the hot water of the following:  Description of the surveyor and the revealed the following:  Description of the following:  Desc	W 4				
	Upon immediate not temperature on 01/1 the maintenance entemperatures. The indicated that the with turned down to achieve the contemperature again.  On 01/11/19, at 2:10 maintenance employ temperatures again. Kitchen faucet - 110 First floor bathroom Basement bathroom Basement bathroom Basement bathroom Basement bathroom CFR(s): 483.470(l)(). The facility must protect avoid sources and This STANDARD is Based on observation of the need of the contemperature and potential transmedication administ residing in the home. Findings included:	otification of the hot water 11/19, the QIDP reported to imployee to check the water maintenance employee atter temperature would be lieve the 110°F for safety.  O PM, the surveyor and the oyee checked the hot water, which revealed the following: 0°F 1-110°F in-108°F oy, the facility failed to ensure erature did not exceed 110°F. ROL 1)  Ovide a sanitary environment of transmission of infections.  In not met as evidenced by: ions, interview and record nursing staff failed to environment to avoid sources inssion of infections during tration, for one of five clients of (Client #5).					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		09G071	B WING	·		01/	11/2019	
1	PROVIDER OR SUPPLIER  OR RESEARCH ASSO				STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
W 454	to check Client #2' client's blood glucothe used blood gluinside the kitchen to the trivial that the was thrown out in that he should have lancet inside the street Review of the facility failed to show infect disposal of glucom lancet.  At the time of survey implement measures.	s blood glucose. After the ose was taken, the LPN threw cose test strip and lancet trash can.  /19 at 6:55 AM, the LPN glucose test strip and lancet the trash can. The LPN stated e thrown the test strip and	W	454	The RN retrained the LPN responsion of the Glucometer on properly disposinitem after checking blood sugar levels2-1-19  The task will now be completed area where the Sharps containes stored to make it easier for the Liproperly dispose of items that need disposed of in that manner	g of the  n the is PNs to ed to be		

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD03-0023 01/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE **TAG** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1000 INITIAL COMMENTS 1 000 A licensure survey was conducted from 01/09/19 to 01/11/19. A sample of three residents was selected from five males. 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. GHIID - Group Home for Individuals with Intellectual Disabilities QIDP - Qualified Intellectual Disabilities Professional F - Farenheit The water temperature was lowered to 110 degrees during the survey 1090 1090 3504.1 HOUSEKEEPING process...2-1-19 Staff members were retrained to check The interior and exterior of each GHMRP shall be water temperature daily and record the maintained in a safe, clean, orderly, attractive, temperature obtained. If that temperature and sanitary manner and be free of is above 110 degrees, staff members accumulations of dirt, rubbish, and objectionable were instructed to contact the Home odors. Manager for immediate follow up...2-4-19 This Statute is not met as evidenced by: The Home Manager checked the Based on observation and interview, the GHIID thermometers for each home to ensure failed to ensure that the water temperature did all were working properly (they are)...2-1not exceed 110°F, for five of five residents 19 residing in the facility (Client #1, 2, 3, 4, and 5). Findings included: During the environmental inspection on 01/11/19, at 1:35 PM, water from the faucet of the kitchen sink was hot to touch. When measured, the water temperature was determined to be 115°F. Continued inspection of the first floor and second floor sinks and bathrooms also revealed hot water that exceeded 110°F as evidenced by the

Health Regulation & Licensing Administration

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

JUBYOTITLE QUPD

(X6) DATE 10

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING: HFD03-0023 01/11/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION ID PREFIX (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) 1 090 Continued From page 1 1090 following: Kitchen faucet - 115°F First floor bathroom - 114°F Basement bathroom - 114°F On 01/11/19 the QIDP was interviewed at 1:38 PM, concerning the hot water temperatures. The QIDP acknowledged that the water was hot and exceeded the required temperature of 110°F. According to the QIDP, two of five residents have adaptive and cognitive capabilities to control water temperatures. Upon immediate notification of the hot water temperature on 01/11/19, the QIDP reported to the maintenance employee to check the water temperatures. The maintenance employee indicated that the water temperature would be turned down to achieve the 110°F for safety. On 01/11/19, at 2:10 PM, the surveyor and the maintenance employee checked the hot water temperatures again, which revealed the following: Kitchen faucet - 110°F First floor bathroom - 110°F Basement bathroom- 108°F At the time of survey, the facility failed to ensure that the water temperature did not exceed 110°F. 1095 3504.6 HOUSEKEEPING 1095 Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.

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Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD03-0023 01/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BEHAVIOR RESEARCH ASSOCIATES WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1 095 Continued From page 2 1095 This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to store poisonous agents in a locked cabinet and/or out of direct reach of each A combination lock has been purchased resident, for five of five residents of the facility and placed on the storage area where (Residents #1, 2, 3, 4 and 5). the cleaning products and other poisonous items are stored. Only Findings included: appropriate staff was given the combination and staff was re-trained on During the entrance conference on 01/09/19 at approximately 11:30 AM, the QIDP revealed that ensuring these materials are properly Resident #1, 2, 3, 4 and 5 are not competent to stored at all times when not in use...2-4make decisions regarding their health and safety. 19 According to the QIDP, the resident's functioning level is profound. On 01/11/19, beginning at 1:22 PM, observations revealed cleaning supplies such as Windex, oven cleaner, disinfectants and bathroom cleaners were labeled poisonous if swallowed. These poisonous agents were stored in an unlocked closet in the basement bathroom and a bottle of disinfectant was located under the sink in the first floor bathroom. The QIDP who was present at the time of the inspection confirmed that the cleaning supplies were not locked and secured. At the time of the survey, the facility failed to ensure potentially poisonous and/or caustic agent was stored and locked and out of the potential reach of each resident, as required. 1 226 3510.5(c) STAFF TRAINING 1226 Each training program shall include, but not be limited to, the following:

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Health	Regulation & Licensin	g Administration			1 Ortivi	AFFROVED
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3:	(X3) DATE COMP	SURVEY LETED
		HFD03-0023	B. WING		01/1	1/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BEHAV	OR RESEARCH ASSO	CIATES	STON, DC 2	20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 226	Continued From pa	ge 3	1 226			
	This Statute is not a Based on observation review, the GHIID's maintain a sanitary and potential transmedication administ residents residing in Findings included:  Observation of the mat 6:20 AM, revealed to check Resident #resident's blood glucthrew the used blood inside the kitchen trail. Interview on 01/10/1 confirmed that the gout in the trash can, should have thrown inside the sharps con Review of the GHIID failed to show infecting disposal of glucomediancet.  At the time of survey implement measures.	for staff and residents;  met as evidenced by: ons, interview and record nursing staff failed to environment to avoid sources nission of infections during tration, for one of five the home (Resident #5).  medication pass on 01/10/19 d LPN #1 used a Glucometer 2's blood glucose. After the cose was taken, the LPN d glucose test strip and lancet ash can.  9 at 6:55 AM, the LPN lucose test strip was thrown The LPN stated that he the test strip and lancet intainer.  's policy and procedures, on control procedures for ter blood test strips and	1220	The RN retrained the LPN respon for improperly disposing of the Glucometer on properly disposing item after checking blood sugar levels2-1-19 The task will now be completed in area where the Sharps container stored to make it easier for the LP properly dispose of items that need disposed of in that manner2	of the the is Ns to ed to be	
l <b>422</b>	3521.3 HABILITATIO	N AND TRAINING	l 422			
	Each GHMRP shall p	provide habilitation, training				

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B. WING HFD03-0023 01/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) 1 422 Continued From page 4 1422 and assistance to residents in accordance with The staff member in question received the resident 's Individual Habilitation Plan. appropriate disciplinary action for failure to support Client #1 to eat with his peers This Statute is not met as evidenced by: and for failure to implement his measure Based on record review, observation, and objective to improve his skills in eating interview the GHIID failed to implement each independently with others...2-4-19. resident's recommended active treatment All staff members were retrained on the program, for one of three residents in the sample measurable objective and on the (Resident #1). importance of Client #1 developing both the social skills and the eating skills Findings included: needed to eat out and among others....2-On 01/09/19, at 11:25 AM, review of Resident 4-19 #1's IPP, dated 06/2018 to 06/2019, revealed an objective that stated, "During mealtime. <Resident's name > will reduce incidents of grabbing others food while at the table during mealtime daily for six consecutive months." Observation on 01/09/19 at 6:58 PM, revealed Residents #2, 3, 4 and 5 sat at the dining room table for dinner. During this time. Resident #1 stayed in his bedroom with his one to one staff (DSP #1). When asked, DSP #1 stated that Resident #1 will eat after everyone has finish their meal. At 7:32 PM, once Resident #2, 3, 4 and 5 completed their meal, DSP #1 assisted Resident #1 to the dining room table for dinner. Observation on 01/10/19 at 6:50 AM, revealed Resident #1 ate breakfast after Resident #2, 3, 4, and 5. On 01/10/19 at 1:16 PM, interview with the QIDP revealed that Resident #1 should always eat with the other residents. The QIDP also confirmed that Resident #1 has a goal to reduce incidents of grabbing the residents food, therefore, the resident was required to eat with his peers.

Health F	Regulation & Licensi	ng Administration			ONN	AFFROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE	
			A. BUILDING	S:		
	=	HFD03-0023	B. WING		01/1	1/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BEHAVIO	OR RESEARCH ASSO	OCIATES WASHING	TON, DC 2	20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 500	Continued From pa	age 5	1 500			
1 500	3523.1 RESIDENT	'S RIGHTS	1500			
7	that the rights of reprotected in accord chapter, and other laws.  This Statute is not	dence director shall ensure sidents are observed and lance with D.C. Law 2-137, this applicable District and federal met as evidenced by:  on, interview and record		The staff member in question re appropriate disciplinary action to support Client #1 to eat with hand for failure to implement his objective to improve his skills in independently with others2-4-All staff members were retrained measurable objective and on the	or failure his peers measure eating 19. d on the	
	review, the GHIID face exercise their right	ailed to allow each resident to regarding eating breakfast and lates, for one of five residents		measurable objective and on the importance of Client #1 develop the social skills and the eating s needed to eat out and among of 4-19	ing both kills	
	Findings included:					
	Residents #2, 3, 4 a table for dinner. Durstayed in his bedroo (DSP #1). When as Resident #1 will eat their meal. At 7:32 Fand 5 completed the Resident #1 to the cobservation on 01/2	D9/19 at 6:58 PM, revealed and 5 sat at the dining room ring this time, Resident #1 om with his one to one staff sked, DSP #1 stated that after everyone has finished PM, once Resident #2, 3, 4 eir meal, DSP #1 assisted dining room table for dinner. 10/19 at 6:50 AM revealed akfast after Resident #2, 3, 4,				
	revealed that Residents. Residents. Resident #1 has a grabbing the resider resident was require	PM, interview with the QIDP ent #1 should always eat with The QIDP also confirmed that loal to reduce incidents of his food, therefore, the ed to eat with his peers.  PM, a second review of				
		lated 06/2018 to 06/2019,				

Health Regulation & Licensing Administration (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING HFD03-0023 01/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BEHAVIOR RESEARCH ASSOCIATES **WASHINGTON, DC 20019** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX **PREFIX** DATE TAG TAG DEFICIENCY) 1500 Continued From page 6 1500 revealed an objective that stated, "During mealtime, <Resident's name > will reduce incidents of grabbing others food while at the table during mealtime daily for six consecutive months." At the time of the survey, the facility failed to allow Resident #1 to eat breakfast and dinner with his housemates.

PRINTED: 02/05/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		09G071	B. WING		01	01/11/2019	
NAME OF I	PROVIDER OR SUPPLIER	1	ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE		
BEHAVIO	OR RESEARCH ASS	OCIATES	W	ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
		eparedness survey was 1/09/19 through 01/11/19					
		e survey were based on iew of the emergency gram.					
		are abbreviations that may the body of this report.					
:	HM - House Manag	lan Preparedness Program					
E 037	Professional EP Training Progra CFR(s): 483.475(d	am	E 037				
	(1) Training progra ASCs, PACE organ	m. The [facility, except CAHs, nizations, PRTFs, Hospices, es] must do all of the following:					
	policies and proced staff, individuals pr	emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their					
	(ii) Provide emerge least annually.	ency preparedness training at					
	(iv) Demonstrate st procedures.	taff knowledge of emergency 482.15(d) and RHCs/FQHCs					
	at §491.12:] (1) Tra or RHC/FQHC] mu	st do all of the following: emergency preparedness					
	•	DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE (	WHO TITLE OF	T	(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 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 A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G071	B. WING_		01/11/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BEHAVIO	OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 037	Continued From pa	ge 1	E 03	7		
	policies and proced staff, individuals pro arrangement, and vexpected roles.  (ii) Provide emerger least annually.  (iii) Maintain docum (iv) Demonstrate staprocedures.  *[For Hospices at §4 hospice must do all (i) Initial training in epolicies and procedures employees, services under arrangement expected roles.  (ii) Demonstrate staprocedures.  (iii) Provide emerger least annually.  (iv) Periodically revidemergency prepared employees (includin special emphasis plaprocedures necessate others.  *[For PRTFs at §444 program. The PRTF (i) Initial training in epolicies and procedustaff, individuals program arrangement, and vexpected roles.  (ii) After initial training preparedness training preparedness training preparedness training preparedness training expected roles.	ures to all new and existing oviding on-site services under olunteers, consistent with their ncy preparedness training at entation of the training.  aff knowledge of emergency  418.113(d):] (1) Training. The of the following: emergency preparedness ures to all new and existing and individuals providing and individuals providing angement, consistent with their ff knowledge of emergency preparedness training at ew and rehearse its dness plan with hospice g nonemployee staff), with aced on carrying out the ary to protect patients and  1.184(d):] (1) Training must do all of the following: mergency preparedness ures to all new and existing viding services under olunteers, consistent with their g, provide emergency	E 03			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		09G071	B. WING	_		01	/11/2019	
NAME OF PROVIDER OR SUPPLIER  BEHAVIOR RESEARCH ASSOCIATES					REET ADDRESS, CITY, STATE, ZIP CODE  ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SHOULD BE COMPLETION		
	procedures. (iv) Maintain docum preparedness training in expected and procedustaff, individuals programment, contravolunteers, consisted (ii) Provide emerger least annually. (iii) Demonstrate stapprocedures, including what to do, where to case of an emergen (iv) Maintain document in the procedures of an emergen (iv) Maintain document in the procedures of an emergen (iv) Maintain document in the provide initial traingreparedness policies and existing staff, includer arrangement, with their expected result in the procedures. All new and assigned specifithe CORF's emergent their first workday. Tinclude instruction in	entation of all emergency ng.  .84(d):] (1) The PACE of all of the following: emergency preparedness sures to all new and existing viding on-site services under actors, participants, and nt with their expected roles. In act of the following participants of go, and whom to contact in cy. entation of all training.  5.68(d):](1) Training. The fine following: ning in emergency es and procedures to all new dividuals providing services and volunteers, consistent	E	037				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09G071	B. WING		01/11/2019	
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			REET ADDRESS, CITY, STATE, ZIP CODE ASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
	The CAH must do a (i) Initial training in a policies and proced reporting and exting and where necessal personnel, and gue cooperation with fire authorities, to all ne individuals providing and volunteers, con roles.  (ii) Provide emerged least annually.  (iii) Maintain docum (iv) Demonstrate staprocedures.  *[For CMHCs at §48 CMHC must provide preparedness polici and existing staff, in under arrangement, with their expected and documentation of the demonstrate staff knocedures. Therea emergency prepared annually.  This STANDARD is Based on interview failed to ensure each knowledge of the en (specifically describit tracking system use	6.625(d):] (1) Training program. all of the following: emergency preparedness lures, including prompt guishing of fires, protection, any, evacuation of patients, sts, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, esistent with their expected ancy preparedness training at entation of the training. aff knowledge of emergency es and procedures to all new idividuals providing services and volunteers, consistent roles, and maintain e training. The CMHC must mowledge of emergency fter, the CMHC must provide dness training at least and record review, the facility in staff demonstrated inergency procedures ing and/or demonstrating the d to document locations of ing an emergency event), for	E 037			

CEITTE	THE POST WEDICATE	WINEDIO/IID OF ILLIANOFO			CIVID IVC	7. 0930-0381	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G071	B. WING		01	/11/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	<b>E</b>		
BEHAVI	OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	Findings included:  On 01/10/19 beginn asked about the factor tracking the local clients during an evistaff would take a hand fill out the facilitialso said if staff and the facility's vans, the facility as a can be tracked. When asked, the Quarter tracked on the EPP.  On 01/10/19 at 2:03 EP dated 05/20/18 controlled to evacuate via the tracking devices and and computers.  On 01/10/19 at appro1/11/19 at 1:19 PM DSP #5 said during received initial and a facility's emergency they were aware of the subset of track clients emergency event, D'yes". When asked tracking system to dictients and staff duri #4 and DSP #5 state and QIDP.  At the time of the subset is the facility of the subset of the sub	ning at 1:32 PM, the QIDP was bility's emergency procedures ation(s) of staff and sheltered accuation. The QIDP said that ead count, call the manager ty's relocation form. The QIDP of clients' had to evacuate via the vans have tracking devices by telephone and computers. IDP stated that all staff was initially and in August 2018.  IDP stated that all staff was initially and in August 2018.  IDP stated the QIDP's would take a head count, call to out the facility's relocation to said if staff and clients' had facility's vans, the vans have do can be tracked by telephone froximately 4:15 PM and on the procedures. When asked if the facility's tracking system	E 03	The Senior QIDP retrained al members on the protocols for responding to emergency situ specific attention given to pre and properly evacuating the lewhen necessary2-4-19 Staff will receive refresher traminimum twice annually and observed during fire and emedrills by management staff. Thereceive feedback immediately drill on what was done well ar needs to be improved and this will be documented2-20-19	properly ation with paring for ocations ining at will be regency ney will after the ad what is training		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		09G071	B. WING 01			/11/2019
	PROVIDER OR SUPPLIER  OR RESEARCH ASSO			REET ADDRESS, CITY, STATE, ZIP CODE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETION	
E 037	Continued From pa emergency procede		E 037			
						4