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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		100 411	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/2018
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	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
W 000	INITIAL COMMEN	TS	W 0	00	
	03/06/18 through 0 clients was random of five men with va disabilities. This su the fundamental su. The findings of the observations, internadministrative reco	survey were based on views, and review of client and			8
W 120	Professional SLP- Speech Lang	ort Professional pport Plan tellectual Disabilities uage Pathologist DED WITH OUTSIDE	W 1	20	
	The facility must as meet the needs of	ssure that outside services each client.		The day program staff has been independence during mealtime	retrained on 3/7/18
	Based on observa review, the day pro promote each clien independence duri	is not met as evidenced by: tion, interview and record gram failed to consistently it's maximum level of ng lunch time, for one (1) of the core sample. (Client #1)		In the future the QDDP will more compliance by working with the the day program to ensure train by the appropriate clinician on Mealtime services.	e supervisor at ning is conducted
	Findings included:				
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	INATURE (George BujgaTITLE QDDD	(X8) 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

Facility ID: 09G071

If continuation sheet Page 1 of 4

program participation.

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES		-	FORM APPROVED
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/2018
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BEHAVIC	R RESEARCH ASSO		v	ASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(FACH 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 COMPLETION
W 120	the day program she chicken, potatoes a plate independently one-hundred perce independently. At 1 showed that DPS # chocolate pudding. four (4) ounces of volient independently cup before placing 12:06 PM, continue DPS #1 held the cumouth as the client On 03/06/18, at 12: interviewed said the independent with everbal prompts. Ad Client #2 was not a independent during On 03/06/18, at 3:4 was conducted with manager regarding during lunch. The fif #2 was independent during lunch. Additional that DPS #1 should and drink independent that the DPS's wouthe client's maximulating lunch time of the conducted with the DPS's wouthe client's maximulating lunch time of the client #2 esweet potatoes, an plate independently on 03/06/18, at 6:0 showed Client #2 esweet potatoes, an plate independently	50 AM, lunch observations at lowed Client #2 eating puree and sweet peas from a divided of The client consumed of (100%) of the meal 1:57 AM, observations 1 spoon fed Client #2 At 12:02 PM, DPS #1 poured vater into Client #2's cup. The y drank a sip of water from the the cup back on the table. At the doservations showed that up of water up to the Client #2's drank from the cup. 108 PM, DPS #1 when at Client #2 was very ating and drinking when given ditionally, DPS #1 said that llowed to eat or drink llowed to eat or drink lunch time. 12 PM, a telephone interview of the day program's floor Client #2's self-management floor manager said that Client when eating and drinking ionally, the floor manager said if have allowed Client #2 to eat lently. The floor manager said id be re-trained on promoting im level of independence in 03/07/18.	Ī		
	continued observat	tions of the meal showed Clien	t		

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G071	B. WING			03/08/2018
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	
BEHAVIO	OR RESEARCH ASSO	CIATES		WAS	HINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	independently. On 03/06/18, at 6:0 SLP assessment d Client #2 "primarily supervision". At the time of the s failed to allow Clier	ige 2 thick liquids from a cup 5 PM, review of Client #2's ated 07/14/17, showed that feeds self with close urvey, the day program staff at #2 to exercise independence to the full extent of the client's	W	120		
W 192	STAFF TRAINING CFR(s): 483.430(e		W	192		
	must focus on skill toward clients' hea				The day program staff has been rimplementation of the mealtime well food and beverage texture of mealtime3/7/18	protocol as
	Based on observa review, the day pro- each staff was train each client's mealt	is not met as evidenced by: tions, interview and record gram staff failed to ensure that ned effectively to implement time protocol, for the one (1) of the core sample with moderate ient #2)			In the future the QDDP will mon compliance by working with the the day program to ensure train by the appropriate clinician on Mealtime services.	ing is conducted
	Findings included:					
	showed DPS #1 pointo the client's cup water from the cup	:02 AM, lunch observations oured four (4) ounces of water of the client drank a sip of before placing the cup back was no coughing observed ink the water.				

On 03/06/18, at 6:08 PM, dinner time

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		AND HUMAN SERVICES					RM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		CONSTRUCTION		DATE SURVEY COMPLETED
		09G071	B. WING				03/08/2018
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	ı	
BEHAVIO	OR RESEARCH ASSO	CIATES		WA	ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 192	Continued From pa	ige 3	w	192			
	observations show	ed DSP #2 adding thickener to					
k	Client #2's beverag	e. When asked, DSP #2 said					
	that Client #2's reco all meals.	eived nectar thick liquids with					
	interviewed via tele lunch observations that Client #2 drant DPS #1 then said t have been of a neo asked, DPS #1 said staff on Client #2's	phone regarding Client #2's on 03/06/18. DPS #1 said the water without thickener. hat the client's water should that the facility had trained all mealtime protocol.					
	ISP dated 06/03/17 presented with mod review of the ISP s	14 PM, review of Client #2's If showed that the client If derate oral dysphagia. Further If howed that Client #2's liquids If thick consistency.					
	program's in-service	10 PM, review of the day be training records showed all i #1 received training on Client ocol on 09/01/17.					
	ensure all staff was	survey, the facility failed to s effectively trained to 2's mealtime protocol.					d

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Health Regulat	ion & Licensin	g Administration			
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HFD03-0023	B WING		03/08/2018
NAME OF PROVIDE	R OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	20
BEHAVIOR RES	SEARCH ASSO	CIATES WASHING	STON, DC 20	019	
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES V 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 COMPLETE
1 000: INITI	AL COMMENT	rs	1 000		
through was remained the disable of the feather and a superior of the feather appears to th	gh 03/08/18. Andomly select with varying designations of the evations, interest and ministrative. The below a lar throughout. Day Program	re abbreviations that may the body of this report.			
GHill Intelle ISP - QIDP Profe) - Group Hon ectual Disabilit Individual Sup Qualified In ssional	nes for Individuals with ies	i i		
i 422 3521.	3 HABILITATI	ON AND TRAINING	1 422		
and a	ssistance to r	provide habilitation, training esidents in accordance with vidual Habilitation Plan.		The day program staff has beer implementation of the mealtim well food and beverage texture mealtime3/7/18	e protocol as
Base revieventhat entire imple lunchent (1) of (Resi	d on observative, the GHIID's each staff was ment each clicatime, as recount the three (3) dent #2)	met as evidenced by: on, interview and record day program failed to ensure trained effectively to ent's mealtime protocol, during mmended by the SLP for one residents in the core sample.		In the future the QDDP will mo compliance by working with th the day program to ensure trai by the appropriate clinician on Mealtime services.	e supervisor at ning is conducted
(Resi		residents in the core sample.			Nutrition and



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Health Regulation & Licensin	g Administration	ment has a TIPLE	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING:	CONSTRUCTION	COMPLETED
AND I DAY OF BOTH TOWN		,, boiles		
	HFD03-0023	B. WING		03/08/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
	ACIATES			
BEHAVIOR RESEARCH ASSO	WASHING	STON, DC 200		ION (X5)
FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TD BE COMPTETE I
1 422 Continued From pa	age 1	1 422		
	:02 AM, lunch observations	1		
showed DPS #1 po	oured four (4) ounces of water			
into Resident #2's	cup. The resident drank a sip			
or water from the c	cup before placing the cup back was no coughing observed			
when Resident #2	drank the water.			
On 03/06/19 at 6:0	08 PM, dinner observations			
showed DSP #2 ac	dding thickener to Resident			
#2's beverage, Wh	en asked, DSP #2 said that			
	ived nectar thick liquids with all			
meals.				
On 03/07/18, at 9:3	35 AM, DPS #1 was			
interviewed via tele	ephone regarding Resident #2's on 03/06/18. DPS #1 said that			
Resident #2 drank	the water without thickener.			
DPS #1 then said	that the water should have			
been of a nectar tr	nick consistency. When asked, he facility had trained all staff			
on Resident #2's n	nealtime protocol.			
0 00/07/40 0	04 DM raview of Recident #2's			
ISP dated 06/03/1	04 PM, review of Resident #2's 7 showed that the resident			
presented with mo	derate oral dysphagia. Further			
review of the ISP s	showed that Resident #2's of a nectar thick consistency.			
·				
On 03/07/18, at 2:	10 PM, review of the day			
program's in-servi	ce training records showed all S #1 received training on			
Resident #2's mea	altime protocol on 09/01/17.			
At the time of the	survey, the facility failed to as effectively trained to			
implement Reside	ent #2's mealtime protocol.			
The Section of the Se				*
T				

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

PRINTED: 04/04/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1		09G071	B. WING_		02/02/02/0
NAME OF	PROVIDER OR SUPPLIER		' T	STREET ADDRESS, CITY, STATE, ZIP CODE	03/08/2018
BEHAVIO	OR RESEARCH ASSO	I TO THE RESERVE TO THE PARTY OF THE PARTY O		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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
E 000	Initial Comments		E 00	0	
	An emergency prep conducted on 03/06	paredness survey was /18 through 03/08/18.			
	The findings of the s interviews and revie administrative recon	survey were based on w of resident and ds.	a a	<i>y</i> :	
	Note: The below are appear throughout the	e abbreviations that may ne body of this report.		2	
	EP - Emergency Pla EPP - Emergency Pi QIDP - Qualified Inte Professional	reparedness Plan ellectual Disabilities			
E 006	Plan Based on All Ha CFR(s): 483.475(a)(azards Risk Assessment 1)-(2)	E 00	5	
	and maintain an emethat must be reviewe	The [facility] must develop ergency preparedness plan ed, and updated at least lust do the following:]			
	facility-based and co	include a documented, mmunity-based risk an all-hazards approach.*	į	BRA has been working on this elements of its Emo Preparedness plan and has attached this service r	esponse, 4-6-18
	on and include a doc community-based ris	§483.73(a)(1):] (1) Be based umented, facility-based and k assessment, utilizing an including missing residents.	ו	he contact with the prescribed officials will occu	r by4-23-18
, (and Include a docume community-based ris	3.475(a)(1):] (1) Be based on ented, facility-based and k assessment, utilizing an including missing clients.			
		s for addressing emergency	<u></u>	- A-DD	
BURATURY	DIRECTORS OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE WI'N	(XB) DATE 1 C

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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		A MEDICALD CEDVICES		0	MD NO DOSO DOS
		& MEDICAID SERVICES			MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/2018
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BEHAVIO	OR RESEARCH ASSO	CIATES	V	ASHINGTON, 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 COMPLÉTION
E 006	Continued From pa	ge 1	E 006		
	· ·	the risk assessment.			
	strategies for addresidentified by the risl management of the failures, natural dist that would affect the care. This STANDARD is Based on interview failed to collaborate program to determinecessary to ensure be provided during facility-based and cassessment, for five outside day program. Findings included: On 03/08/17, begin was asked about if programs were incompressed as a see that the facility's risk at the facility's risk at the facility's administ EP with Client #3's On 03/08/17, at 10: EPP dated 11/21/16 showed a lack of case and so that the facility is administ EP with Client #3's	At 18.113(a)(2):] (2) Include essing emergency events assessment, including the econsequences of power asters, and other emergencies hospice's ability to provide and record review, the facility with each client's day ne what arrangements where that essential services could an emergency as part of their ommunity-based risk (5) of 5 clients attending an m. (Client #1, 2, 3,4 and 5) Ining at 10:36 AM, the QIDP Client #1, 2, 3,4 and 5's day or porated into the development assessment. The QIDP said not include any of the client's edevelopment of the facility's owever, the QIDP said that strator had verbally shared the day program provider. 57 AM, review of the facility's and updated on 01/25/18, ollaboration with Client #1, 2, gram to ensure that essential provided during an emergency.			

At the time of the survey, the facility failed to show that the client's day programs were included

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

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CENTER	49 FOR WEDICARE	& IVIEDICAID SERVICES					MD MO. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`'	TIPLE CONSTRUC			(X3) DATE SURVEY COMPLETED
		09G071	B. WING				03/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CO	ODE	
BEHAVIO	OR RESEARCH ASSO	CIATES		WASHINGTO	ON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EAC	OVIDER'S PLAN OF COR H CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	SHOULD	BE COMPLÉTION
E 006	Continued From pa	ge 2	ΕO	06			
'	in the development	of the facility's EPP.					
E 009	Local, State, Tribal CFR(s): 483.475(a)	Collaboration Process (4)	E 0)9			
	and maintain an em that must be review	n. The [facility] must develop nergency preparedness plan red, and updated at least must do the following:]					
	(4) Include a proces	ss for cooperation and	E	009			
	collaboration with lo	cal, tribal, regional, State, and		DA has been would	ldon on this standard of the		
		preparedness officials' efforts rated response during a			king on this elements of it and has attached this ser	•	· ·
		ncy situation, including	_				
		e facility's efforts to contact		he contact with th	he prescribed officials will	occur by	/4-23-18
ļ		when applicable, of its borative and cooperative					
	Include a process for collaboration with lo Federal emergency to maintain an integration of the contact such official participation in colla planning efforts. The the local emergency	cal, tribal, regional, State, and preparedness officials' efforts rated response during a ney situation, including the dialysis facility's efforts to s and, when applicable, of its borative and cooperative to dialysis facility must contact or preparedness agency at					
	of the dialysis facility emergency.	nfirm that the agency is aware y's needs in the event of an					
		s not met as evidenced by: eview and interview, the facility					
		itten policies and procedures					
	to ensure cooperation	on and collaboration with					
1	local, regional, state	and federal EP officials					

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		& MEDICAID SERVICES		- umuuu	OMB NO. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/3048
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/08/2018
BEHAVI	OR RESEARCH ASSO			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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 009	efforts to ensure an disaster, for five (5) facility. (Clients #1, Findings included:	integrated response during a of 5 clients residing in the 2, 3, 4 and 5)	E OC	09	
	EP dated 11/21/17, facility collaborated federal EP officials to response during a domain on 03/08/18, at 11:1 an interview that the not contacted the affi	7 AM, the QIDP said during facility's administrators had prementioned officials to I response during a disaster			
E 015 .	that the facility devel that ensured cooper- local, regional, state efforts to ensure an i disaster.	rvey, there was no evidence oped policies and procedures ation and collaboration with and federal EP officials' integrated response during a for Staff and Patients	E 01	5	
= ;	develop and implemond policies and procedured plan set forth in parages assessment at parage and the communication this section. The police is the police of	cedures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk traph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be d at least annually.] At a s and procedures must		E015 The policy has been developed is attached for 4-6-18	evlew by licensure.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/04/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G071 B. WING 03/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BEHAVIOR RESEARCH ASSOCIATES WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 015 Continued From page 4 E 015 (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. (3) Fire detection, extinguishing, and alarm

(C) Sewage and waste disposal.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility
failed to develop written policies and procedures

systems.

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		AND HUMAN SERVICES			FORM APPROVE
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	_		OMB NO. 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G071	B. WING_		02/00/0040
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP C	03/08/2018 ODE
BEHAVI	OR RESEARCH ASSO			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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
E 015	Continued From pa	ge 5	E 01	5	
	and alarm systems, during emergency s	fire detection, extinguishing sewage and waste disposal ituations for five (5) of 5 e facility. (Clients #1, 2, 3, 4			
•	Findings included:				
	the facility's EP date evidence that policie developed to include extinguishing and al	ning at 11:34 AM, review of ad 11/21/17, showed no as and procedures had been adequate fire detection, arm systems, sewage and ag emergency situations.			
	an interview that the another facility that he the event of an emer When asked if there procedures outlined aforementioned systems.	8 AM, the QIDP said during clients would be relocated to had a natural gas generator in regency or power outage. were written policies and in the EP to maintain the ems the QIDP said "the res are in the process of			
E 018	that the facility develon that addressed fire d alarm systems, sewa during emergency sit Procedures for Track	ing of Staff and Patients	E 018		
(CFR(s): 483.475(b)(2	(2)		E 018	
ر ا ا	develop and impleme policies and procedu plan set forth in parag	redures. The [facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section,	je	Tracking procedures for staff and peop in the policy for emergency/disaster sit this document) but a separate policy w	uations (submitted with

	AND HUMAN SERVICES			FORM APPROV
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
	09G071	B. WING _		03/08/2018
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0010010010
OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	LO BE 🕛 COMPLÉT
Continued From page	ge 6	F 018		
and the communica	ition plan at paragraph (c) of			
reviewed and updat	licies and procedures must be ed at least annually 1 At a			
minimum, the policie	es and procedures must	85		
address the followin	g :]			
patients are relocate	ed during the emergency, the			
*[For PRTFs at §441	1.184(b), LTC at §483.73(b),			
ICF/IIDs at §483.475	(b), PACE at §460.84(b):]			
location of on-duty s	taff and sheltered residents in			
sheltered residents a	are relocated during the			
emergency, the [PR] must document the	TF's, LTC, ICF/IID or PACE] specific name and location of			
the receiving facility	or other location.			
*[For Inpatient Hospi	ce at §418.113(b)(6):]			
Policies and procedu (ii) Safe evacuation f	ires. from the hospice, which			
includes consideration	on of care and treatment		0	
	PROVIDER OR SUPPLIER OR RESEARCH ASSO SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pay and the communica this section. The po reviewed and updat minimum, the policie address the followin (2) A system to track and sheltered patier an emergency. If or patients are relocate [facility] must docum location of the receiv "[For PRTFs at §44." ICF/IIDs at §483.479 Policies and procedu location of on-duty s the [PRTF's, LTC, IC and after an emerge sheltered residents a emergency, the [PR' must document the se the receiving facility "[For Inpatient Hospi Policies and procedu (ii) Safe evacuation fi includes consideration	DF CORRECTION IDENTIFICATION NUMBER:	Continued From page 6 and the communication plan at paragraph (c) of this section. The policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients are relocated during the emergency. If on-duty staff and sheltered patients are relocated during 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] must document the specific name and location of on-duty staff and sheltered residents are relocated during the emergency. If on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of on-duty staff and sheltered residents in 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	TOF DEFICIENCIES OPECORRECTION (X1) PROVIDER/SUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019 WASHINGTON, DC 20019 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 6 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 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 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. "[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.

assistance.

transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of

(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

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G071	B. WING		03/08/2018
NAME OF	PROVIDER OR SUPPLIER	TO THE MICHIGAN IN THE PARTY OF	81	TREET ADDRESS, CITY, STATE, ZIP CODE	1 UUIUUIZUIU
BEHAVIO	OR RESEARCH ASSO	CIATES	W	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 CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
E 018	Continued From page	age 7	E 018		
		specific name and location of	-		
	*[For CMHCs at §4	85.920(b):] Policies and			
	procedures. (2) Sate which includes cons	fe evacuation from the CMHC, sideration of care and			
	treatment needs of	evacuees; staff			
	evacuation location(nsportation; identification of (s); and primary and alternate			
	means of communic assistance.	cation with external sources of			
	procedures. (2) A sy documentation that donor information, p potential and actual	6.360(b):] Policies and ystem of medical preserves potential and actual protects confidentiality of donor information, and lins the availability of records.			
	procedures. (2) Safe	4.62(b):] Policies and evacuation from the dialysis les staff responsibilities, and ts.			
	This STANDARD is Based on interview failed to develop poli	s not met as evidenced by: and record review, the facility licies and procedures to track and sheltered clients during			
		ive (5) of 5 clients residing in			
	Findings included:				
i 	about the facility's me location(s) of staff ar	2 AM, the QIDP was asked nethod of tracking the nd sheltered clients during an DP said that staff would take a			

head count and then call the QIDP. The QIDP also said if staff and clients had to evacuate via the facility's vans, the vans had tracking devices

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/04/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G071 B. WING. 03/08/2018 NAME OF PROVIDER OR SUPPLIER

BEHAVIOR RESEARCH ASSOCIATES

STREET ADDRESS, CITY, STATE, ZIP CODE

WASHINGTON, DC 20019

(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)COMPLÉTION DATE

, E 018 Continued From page 8

and could be tracked by telephone and computers. The QIDP said that the residential staff would maintain communication with the command center, located at the agency's main office, by telephone. In the event that telephones were inoperable there were radios and walkie talkies available for internal communications.

On 03/08/18, at 11:47 AM, the QIDP said during an interview that there was no policy on staff tracking. The QIDP also said that the facility was in the process of developing policy and procedures for locating staff and clients to include sheltering in place and evacuation.

At the time of the survey, the facility failed to establish a means of tracking the location of all staff and sheltered clients during and after emergencies.

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].

E 018

E 022

E 022

The policy for sheltering in place was developed by...4-6-18 The emergency/disaster policy outlines sheltering in place parameters for the various situations considered and the guidance documents outline existing procedures as well.

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		AND HUMAN SERVICES & MEDICAID SERVICES		,	FORM	APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY MPLETED
		09G071	B. WING_		03	/08/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00.4010
BEHAVI	OR RESEARCH ASSO	CIATES		WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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) COMPLETION DATE
E 022	Continued From pa	ge 9	E 02	2		1317
	and procedures. (6) The following an hospice-operated in The policies and profollowing: (i) A means to she hospice employees This STANDARD is Based on record refacility failed to devethat address a mean clients and staff who disaster or emergen	e additional requirements for apatient care facilities only. according to the procedures must address the elter in place for patients, who remain in the hospice. In the mospice will be and interview, the elop policies and procedures and procedures and so of sheltering in place for the procedures are presented in the facility during a procedure, for five (5) of 5 of facility. (Clients #1, 2, 3, 4				
	the facility's EPP, da evidence that the fac	ning at 11:34 AM, review of sted 11/21/17, showed no cility had developed policies ddress sheltering in place for			٩	
	an interview that star do should staff and o place for tornados, a When asked if there procedures outlined place that was aligne assessment, the QID	18 AM, the QIDP said during ff had been trained on what to clients have to shelter in active shooter, hurricane, etc. were policies and in the EP for in sheltering and with the facility's risk DP responded by saying, "the ares are in the process of				

At the time of the survey, there was no evidence that the facility's developed policies and

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMI				OMB NO. 0938-0391	
STATEMENT OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/2018
NAME OF PROV	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
BEHAVIOR R	ESEARCH ASSO			WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
pro	ntinued From pa	EP addressed sheltering in	E 02	22	
E 023 Poli	cies/Procedures R(s): 483.475(b)	encies and disasters. s for Medical Documentation (5)	E 02	23	
dev polic plar asso and this revie mini	elop and implemodes and proced set forth in para essment at para the communica section. The poswed and update	ncedures. The [facilities] must nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually. At a es and procedures must g:]		E023 The medical documentation policy was it should be noted that a copy of each paper of the emergency bag for each pathern in an emergency situation as will	erson that is taken with
pres conf and (3),(that conf	erves patient ini identiality of pat maintains availa 4),(6)] A system preserves patie identiality of pati	ical documentation that formation, protects lent information, and secures ability of records. [(5) or of medical documentation in information, protects lent information, and secures ability of records.			
i proc that ; (i) Pr (ii) P	edures. (5) A sy does the following reserves patient rotects confident secures and mai				
; proc docu	edures. (2) A systementation that p	360(b):] Policies and stem of medical preserves potential and actual preserves confidentiality of			ν,

potential and actual donor information, and

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM	04/04/201 APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION	(X3) DATE). 0938-039 FE SURVEY MPLETED
		09G071	B. WING		00	
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD	U3/1	/08/2018
BEHAVI	IOR RESEARCH ASSO	CIATES	W	ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 023	Continued From pa	ane 11	E 023			
		ains the availability of records.	L VZU			
	Based on record re failed to develop poladdress a system the of client information (5) of 5 clients resided, 3, 4 and 5) Findings included: On 03/08/18, at 11:3	is not met as evidenced by: eview and interview, the facility blicies and procedures that that protects the confidentiality in during an emergency, for five ding in the facility. (Clients #1,				
	procedure had been medical record docu preserved that the c confidentiality of clie	n developed that outlined a umentation system that clients information, protested ent information and secured uliability of records during an				
1	during an interview the procedures that outling documentation system information. The QIE	11:51 AM, the QIDP said that there was no policles and lined a medical record em that preserved client DP said that the facility was in loping the aforementioned ures.				
t	that the facility development that addressed ensured client information.	rvey, there was no evidence loped policies and procedures uring the confidentiality of				
E 024	Policies/Procedures- CFR(s): 483.475(b)(6	-Volunteers and Staffing (6)	E 024			

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness

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	THE THE TENT	WIND LIGHTIA OFIZATORS			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		O	MB NO. 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/2018
NAME OF	PROVIDER OR SUPPLIER		S1	FREET ADDRESS, CITY, STATE, ZIP CODE	
BEHAVIO	OR RESEARCH ASSO		W	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
	plan set forth in para assessment at para and the communical this section. The policie address the followin (6) [or (4), (5), or (7) volunteers in an emistaffing strategies, in for integration of Stahealth care profession during an emergency and othe strategies to address the use of vemergency, for five (facility. (Clients #1, 2) Findings included: On 03/08/18, at 02/0 the facility's EP, date evidence that policies	lures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually. At a less and procedures must ng:] as noted above] The use of pergency or other emergency including the process and role ate and Federally designated donals to address surge needs by: as of volunteers in an er emergency staffing as surge needs during an an are emergency staffing and procedures that volunteers during an (5) of 5 clients residing in the 2, 3, 4 and 5)	BRA h Provide people in the with BRA v local and s by4	mergency staffing protocol was developed by uld be noted that BRA does not plan to use volu- flected in the protocol. has prepared an agreement document with near dence Hospital that will provide emergency sup- le who need it in an emergency situation. BRA a provider community, already has a working rel Providence. The agreement will be presented by will complete the memorandum of understandin hotels used and for the hotels that are at least is submit them to the appropriate hotel personnel 1-23-18 re presenting the documents to the hotel, BRA in to licensing for review and comment.	rby port for as does many lationship y4-23-18. ing for the 25 miles away I to be signed

On 03/0108/18, at 11:52 AM, the QIDP said during an interview that the facility had decided not to use volunteers during emergency

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

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		& MEDICAID SERVICES			MB NO. 0938-0391
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF		09G071	B. WING		03/08/2018
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BEHAVI	OR RESEARCH ASSO		V	VASHINGTON, 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 COMPLETION
E 025	Continued From page	ge 15	E 025	¥	
E 026	that the facility's EP to follow if the client emergency.	irvey, there was no evidence included written procedures in must relocate during an er Declared by Secretary (8)	E 026		
3	policies and procedu plan set forth in para assessment at para and the communical this section. The pol reviewed and update	cedures. The [facilities] must ent emergency preparedness ares, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of cies and procedures must be ed at least annually. At a s and procedures must	ti re ba dur refi BRA	he emergency/disaster policy submitted with the emergency/disaster policy submitted with the sponses outline BRA support parameters during ased on emergency situations. BRA also providering hospital stays and the agreement with Providect that4-6-18 A's intend is to provide staff support wherever sing rendered in an emergency situation.	g hotel stays es support staff idence will
	[facility] under a waiv in accordance with s provision of care and), or (9)] The role of the er declared by the Secretary, ection 1135 of the Act, in the treatment at an alternate remergency management	a		
9 9	procedures. (8) The waiver declared by the with section 1135 of at an alternative care management officials. This STANDARD is Based on record reversiled to develop policidescribe its role in prowith section 1135 of the waith s	3.748(b):] Policies and role of the RNHCI under a se Secretary, in accordance Act, in the provision of care site identified by emergency s. not met as evidenced by: iew and interview, the facility cies and procedures that oviding care in accordance the Stafford Act, during a teral emergency, for five (5)			

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CENTE		& MEDICAID SERVICES			FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		09G071	B WING_		02/09/2049
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/08/2018
BEHAVI	OR RESEARCH ASSO	CIATES		WASHINGTON, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
E 026		ge 16 in the facility. (Clients #1, 2,	E 02	6	
	the facility's EPP, da evidence that the fa and procedures to a	ning at 11:43 AM, review of ated 11/21/17 showed no cility had developed policies address the facility's role in reatment at alternative care waiver.			
	an interview that the body had not develo outlining the facility's declared by the Sec Services or when the	39 PM, the QIDP said during facility and its governing sped policies and procedures role in emergencies retary of Health and Human e President declares a major cy under the Stafford Act.			
E 033	At the time of the suithat the facility's EPF care at alternate site emergencies. Methods for Sharing CFR(s): 483.475(c)(4	Information	E 033	α	u
;	[(c) The [facility] mus emergency prepared that complies with Fe and must be reviewe annually.] The comn all of the following:	st develop and maintain an Iness communication plan ederal, State and local laws id and updated at least nunication plan must include		E033 The method of sharing medical information is of COOP and will be outlined in a specific protocol As mentioned, a copy of the Health Passport is emergency supply bag for each person support their PEPP. This will be mentioned in the protocol This consideration will be outlined in the Comm	l by4-6-18 included in the ed as is a copy of col.
(documentation for pa	ring information and medical itients under the [facility's] with other health providers to		be developed by 4-23-18.	

maintain the continuity of care.

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		09G071	B. WING		03/08/2018
	PROVIDER OR SUPPLIER		S1	REET ADDRESS, CITY, STATE, Z	IP CODE
BEHAVIO	OR RESEARCH ASSO	CIATES	W	ASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE COMPLETION THE APPROPRIATE DATE
E 033	Continued From pa	ge 17	E 033		
	release patient infor CFR 164.510(b)(1)(required for HHAs u under §485.68(c), a §491.12(c).] (6) [(4) or (5)]A mea about the general co	event of an evacuation, to rmation as permitted under 45 ii). [This provision is not ender §484.22(c), CORFs and RHCs/FQHCs under ender en			
	*[For RNHCIs at §40 sharing information a patients under the R with care providers t	03.748(c):] (4) A method for and care documentation for NHCI's care, as necessary, o maintain the continuity of written election statement			
	of providing informat condition and location facility's care as perro 164.510(b)(4). This STANDARD is Based on record revialled to develop writing means the facility information to include	at §491.12(c):] (4) A means ion about the general in of patients under the nitted under 45 CFR not met as evidenced by: view and interview, the facility ten policies that addressed y would use to release client the general condition and in five (5) of 5 clients residing is #1, 2, 3, 4 and 5)			
	Findings included:			*	

On 03/08/18, beginning at 11:34 AM, review of the facility's EP dated 11/21/17, showed no evidence of written policies to ensure the

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/04/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 09G071 **B. WING** 03/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BEHAVIOR RESEARCH ASSOCIATES WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 033 Continued From page 18 E 033 confidentiality of client information, including the general condition and location of clients during an emergency. On 03/08/18, at 12:13 PM, the QIDP was asked about how the communication plan addressed the

procedure was for regarding the release of client information.

At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed the release of information regarding the general condition and location of

means the facility would use to release client information that would include the general condition and location of the clients. The QIDP said that the policies and procedures needed to be developed regarding the release of client information including the general condition and location of the clients. It should be noted that QIDP could verbally describe what the policy and

E 034 Information on Occupancy/Needs CFR(s): 483.475(c)(7)

clients during an emergency.

[(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. E 034

E034

The Communications Plan is attached for review by...4-6-18

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Ì
		09G071	B. WING			03/08/2018	
	PROVIDER OR SUPPLIER OR RESEARCH ASSO	CIATES			EET ADDRESS, CITY, STATE, ZIP CODE	1 03/06/2018	
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	providing information its ability to provide having jurisdiction, to Center, or designed *[For Inpatient Hosp of providing information inpatient occupancy provide assistance, jurisdiction, the Incidesignee. This STANDARD is Based on record refacility's communicate method for providing facility's occupancy.	54(c)]: (7) A means of an about the ASC's needs, and assistance, to the authority the Incident Command bice at §418.113:] (7) A means at the ASC's needs, and its ability to to the authority having dent Command Center, or a not met as evidenced by: view and interview, the tion plan failed to have a grinformation about the to the authority having 5) of 5 clients residing in the	E	34			
	the facility's community showed no evidence information about the authority having juris On 03/08/18, at 12:1 communication plan updated to address tracility, and the facility	sing at 11:56 AM, review of nication plan dated 11/21/17, to of a means for providing the facility's occupancy to the ediction during an emergency. 5 PM, the QIDP said that the was in the process of being the status of clients in the ty's ability to provide care					
4	hat the facility's com	y. vey, there was no evidence munication plan addressed ation to include the general					

emergency.

condition and location of clients during an

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E 025	TC and ICE/IID OF	ania - Dian - M. D. M.		===			

E 035 LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8)

[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility
failed to ensure that its communication plan
described in writing the method used for sharing
its EP and policies with each client and his or her
involved family member or representative, for five
(5) of 5 clients residing in the facility. (Clients #1,
2, 3, 4 and 5)

Findings included:

On 03/08/18, beginning at 11:56 AM, review of the facility's communication plan dated 11/21/17, showed no information regarding the sharing of its EP and policies with clients, involved family members or representatives.

On 03/08/18, at 9:57 AM, Client #2's family member was interviewed via telephone and stated that the facility had not shared information regarding the EP with the family.

On 03/08/18, at 10:00 AM, Client #3's guardian was interviewed via telephone regarding the facility's EP plan. The guardian stated that the facility had shared information regarding the EP

E 035

E 035

As indicated by the Surveyors, the guardians and involved family were informed about the plans being developed but they will be shared once all are completed and approved and this is a significant task that BRA staff is working diligently to complete. BRA priorltized the various associated tasks. The Risk Assessments were completed first as they set the baseline for the associated policies and protocols; the COOP was revised and updated second because the COOP reflects many of the mandated elements; the overall (general) compliance policy was developed and then the emergency/disaster policy next and so forth. Developing and implementing a good staff training was also made a high priority and that was done for all staff.

This document (survey) provides guidance for the remaining elements and will be used to shape them accordingly. As indicated, we will submit documents for review as we complete them as opposed to waiting until all elements are completed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MI

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via e-mail.

E 035

On 03/08/18, at 1:50 PM, the QIDP was interviewed regarding how information from the EP would be shared with clients and families in case of an emergency. The QIDP stated that the facility would communicate with the family and/or guardians via e-mail regarding the EP. Additionally, the QIDP said the EP plan had been shared with the facility's clients. When asked if the communication plan outlined policies and procedures on sharing information with the clients, families and/or guardians, the QIDP responded by saying, "the policies were in the process of being developed".

At the time of the survey, there was no evidence that the facility developed written policies regarding the method(s) for sharing information regarding the emergency plan with clients, their families or representatives.

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E 024	situations. When as procedures related a QIDP responded by been developed". At the time of the su	sked if there were policies and to volunteers in the EPP, the y saying, "the policies had not urvey, there was no evidence addressed the use of	E 024		
	Arrangement with O CFR(s): 483.475(b)([(b) Policies and prodevelop and implem policies and proceduplan set forth in para assessment at paragand the communicat this section. The policies address the following *[For Hospices at §4 §441.184,(b) Hospita Facilities at §483.73(7) [or (5)] The development of the event operations to maintait to facility patients.	ocedures. The [facilities] must be the emergency preparedness by the emergency preparedness by the emergency agraph (a) of this section, risk graph (a)(1) of this section, the emergency agraph (a)(1) of this section, the emergency agraph (c) of licies and procedures must be ead at least annually. At a less and procedures must go and procedures must go are section of limitations or cessation of limitations or cessation of in the continuity of services	who wineed it provide other partners are partners.	as prepared an agreement document with other will partner and provide emergency support for t in an emergency situation. BRA as does many ler community, already has a working relations providers4-6-18. Will complete the memorandum of understanding the with other agencies during emergency situates a Before presenting the documents to the hotel it them to licensing for review and comment.	y in the ship with ing for the for the for the for the for
i j	§485.920(b) and ESF Policies and procedured development of arran	at §486.625(b), CMHCs at RD Facilities at §494.62(b):] ures. (7) [or (6), (8)] The agements with other providers to receive patients			

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		09G071	B. WING		03/08/2018
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
BEHAVIOR RESEARCH ASSOCIATES			W	ASHINGTON, DC 20019	
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	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		E 025		
(On 03/08/18, at 12:0	5 PM, the QIDP said during facility had not obtained a		2	

memorandum of understanding with any hotel(s) in the event that the facility had to be evacuated.