STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G071	A. BUILDING _____ B. WING _____	03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	[redacted] 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) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 03/06/18 through 03/08/18. A sample of three clients was randomly selected from a population of five men with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations, interviews, and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. DPS- Day Program Staff DSP - Direct Support Professional ISP - Individual Support Plan QIDP - Qualified Intellectual Disabilities Professional SLP- Speech Language Pathologist	W 000		
W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) 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 day program failed to consistently promote each client's maximum level of independence during lunch time, for one (1) of three (3) clients in the core sample. (Client #1) Findings included:	W 120	The day program staff has been retrained on independence during mealtime...3/7/18 In the future the QDDP will monitor ongoing compliance by working with the supervisor at the day program to ensure training is conducted by the appropriate clinician on Nutrition and Mealtime services.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Georgia Bryson TITLE QDDP (X6) DATE 5/13/18

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W 120	Continued From page 1	W 120		

On 03/06/18, at 11:50 AM, lunch observations at the day program showed Client #2 eating puree chicken, potatoes and sweet peas from a divided plate independently. The client consumed one-hundred percent (100%) of the meal independently. At 11:57 AM, observations showed that DPS #1 spoon fed Client #2 chocolate pudding. At 12:02 PM, DPS #1 poured four (4) ounces of water into Client #2's cup. The client independently drank a sip of water from the cup before placing the cup back on the table. At 12:06 PM, continued observations showed that DPS #1 held the cup of water up to the Client #2's mouth as the client drank from the cup.

On 03/06/18, at 12:08 PM, DPS #1 when interviewed said that Client #2 was very independent with eating and drinking when given verbal prompts. Additionally, DPS #1 said that Client #2 was not allowed to eat or drink independent during lunch time.

On 03/06/18, at 3:42 PM, a telephone interview was conducted with the day program's floor manager regarding Client #2's self-management during lunch. The floor manager said that Client #2 was independent when eating and drinking during lunch. Additionally, the floor manager said that DPS #1 should have allowed Client #2 to eat and drink independently. The floor manager said that the DPS's would be re-trained on promoting the client's maximum level of independence during lunch time on 03/07/18.

On 03/06/18, at 6:05 PM, dinner observations showed Client #2 eating puree turkey chops, sweet potatoes, and collard greens from a divided plate independently after set-up. At 6:14 PM, continued observations of the meal showed Client

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W 120	Continued From page 2 #2 drinking nectar thick liquids from a cup independently. On 03/06/18, at 6:05 PM, review of Client #2's SLP assessment dated 07/14/17, showed that Client #2 "primarily feeds self with close supervision". At the time of the survey, the day program staff failed to allow Client #2 to exercise independence while eating lunch to the full extent of the client's capabilities.	W 120		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the day program staff failed to ensure that each staff was trained effectively to implement each client's mealtime protocol, for the one (1) of three (1) clients in the core sample with moderate oral dysphagia. (Client #2) Findings included: On 03/06/18, at 12:02 AM, lunch observations showed DPS #1 poured four (4) ounces of water into the client's cup. The client drank a sip of water from the cup before placing the cup back on the table. There was no coughing observed when Client #2 drank the water. On 03/06/18, at 6:08 PM, dinner time	W 192	The day program staff has been retrained on implementation of the mealtime protocol as well food and beverage texture during mealtime...3/7/18 In the future the QDDP will monitor ongoing compliance by working with the supervisor at the day program to ensure training is conducted by the appropriate clinician on Nutrition and Mealtime services.	

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W 192	Continued From page 3	W 192		

observations showed DSP #2 adding thickener to Client #2's beverage. When asked, DSP #2 said that Client #2's received nectar thick liquids with all meals.

On 03/07/18, at 9:35 AM, DPS #1 was interviewed via telephone regarding Client #2's lunch observations on 03/06/18. DPS #1 said that Client #2 drank the water without thickener. DPS #1 then said that the client's water should have been of a nectar thick consistency. When asked, DPS #1 said that the facility had trained all staff on Client #2's mealtime protocol.

On 03/07/18, at 2:04 PM, review of Client #2's ISP dated 06/03/17 showed that the client presented with moderate oral dysphagia. Further review of the ISP showed that Client #2's liquids should be of a nectar thick consistency.

On 03/07/18, at 2:10 PM, review of the day program's in-service training records showed all staff including DPS #1 received training on Client #2's mealtime protocol on 09/01/17.

At the time of the survey, the facility failed to ensure all staff was effectively trained to implement Client #2's mealtime protocol.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0023	A. BUILDING: _____ B. WING _____	03/08/2018

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I 000	INITIAL COMMENTS A licensure survey was conducted from 03/06/18 through 03/08/18. A sample of three residents was randomly selected from a population of five men with varying degrees of intellectual disabilities. 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. DPS- Day Program Staff DSP - Direct Support Professional GHIID - Group Homes for Individuals with Intellectual Disabilities ISP - Individual Support Plan QIDP - Qualified Intellectual Disabilities Professional SLP- Speech Language Pathologist	I 000		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID's day program failed to ensure that each staff was trained effectively to implement each client's mealtime protocol, during lunch time, as recommended by the SLP for one (1) of the three (3) residents in the core sample. (Resident #2) Findings include:	I 422	The day program staff has been retrained on implementation of the mealtime protocol as well food and beverage texture during mealtime...3/7/18 In the future the QDDP will monitor ongoing compliance by working with the supervisor at the day program to ensure training is conducted by the appropriate clinician on Nutrition and Mealtime services.	

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Georgia Briggs TITLE QDDP (X6) DATE 3/13/18

Health Regulation & Licensing Administration

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I 422	Continued From page 1	I 422		

On 03/06/18, at 12:02 AM, lunch observations showed DPS #1 poured four (4) ounces of water into Resident #2's cup. The resident drank a sip of water from the cup before placing the cup back on the table. There was no coughing observed when Resident #2 drank the water.

On 03/06/18, at 6:08 PM, dinner observations showed DSP #2 adding thickener to Resident #2's beverage. When asked, DSP #2 said that Resident #2's received nectar thick liquids with all meals.

On 03/07/18, at 9:35 AM, DPS #1 was interviewed via telephone regarding Resident #2's lunch observations 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 thick consistency. When asked, DPS #1 said that the facility had trained all staff on Resident #2's mealtime protocol.

On 03/07/18, at 2:04 PM, review of Resident #2's ISP dated 06/03/17 showed that the resident presented with moderate oral dysphagia. Further review of the ISP showed that Resident #2's liquids should be of a nectar thick consistency.

On 03/07/18, at 2:10 PM, review of the day program's in-service training records showed all staff including DPS #1 received training on Resident #2's mealtime protocol on 09/01/17.

At the time of the survey, the facility failed to ensure all staff was effectively trained to implement Resident #2's mealtime protocol.

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E 000	Initial Comments An emergency preparedness survey was conducted on 03/06/18 through 03/08/18. The findings of the survey were based on interviews and review of resident and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. EP - Emergency Plan EPP - Emergency Preparedness Plan QIDP - Qualified Intellectual Disabilities Professional	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency	E 006	BRA has been working on this elements of its Emergency Preparedness plan and has attached this service response, 4-6-18 The contact with the prescribed officials will occur by...4-23-18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIDP (X6) DATE 4/5/18

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E 006	Continued From page 1	E 006		

events identified by the risk assessment.

* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to collaborate with each client's day program to determine what arrangements where necessary to ensure that essential services could be provided during an emergency as part of their facility-based and community-based risk assessment, for five (5) of 5 clients attending an outside day program. (Client #1, 2, 3,4 and 5)

Findings included:

On 03/08/17, beginning at 10:36 AM, the QIDP was asked about if Client #1, 2, 3,4 and 5's day programs were incorporated into the development of the facility's risk assessment. The QIDP said that the facility did not include any of the client's day programs in the development of the facility's risk assessment. However, the QIDP said that the facility's administrator had verbally shared the EP with Client #3's day program provider.

On 03/08/17, at 10:57 AM, review of the facility's EPP dated 11/21/16 and updated on 01/25/18, showed a lack of collaboration with Client #1, 2, 3,4 and 5's day program to ensure that essential services would be provided during an emergency.

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

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E 006	Continued From page 2 in the development of the facility's EPP.	E 006		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies and procedures to ensure cooperation and collaboration with local, regional, state and federal EP officials	E 009	E 009 BRA has been working on this elements of its Emergency Preparedness plan and has attached this service response, 4-6-18 The contact with the prescribed officials will occur by...4-23-18	

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E 009	Continued From page 3 efforts to ensure an integrated response during a disaster, for five (5) of 5 clients residing in the facility. (Clients #1, 2, 3, 4 and 5) Findings included: On 03/08/18, at 11:03 AM, review of the facility's EP dated 11/21/17, showed no evidence that the facility collaborated with local, regional, state and federal EP officials to ensure an integrated response during a disaster. On 03/08/18, at 11:17 AM, the QIDP said during an interview that the facility's administrators had not contacted the aforementioned officials to ensure an integrated response during a disaster or an emergency situation. At the time of the survey, there was no evidence that the facility developed policies and procedures that ensured cooperation and collaboration with local, regional, state and federal EP officials' efforts to ensure an integrated response during a disaster.	E 009		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:	E 015	E015 The policy has been developed is attached for review by licensure. 4-6-18	

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E 015	Continued From page 4 (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 systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop written policies and procedures	E 015		

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E 015	Continued From page 5 to ensure adequate fire detection, extinguishing and alarm systems, sewage and waste disposal during emergency situations 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 11:34 AM, review of the facility's EP dated 11/21/17, showed no evidence that policies and procedures had been developed to include adequate fire detection, extinguishing and alarm systems, sewage and waste disposal during emergency situations. On 03/08/18, at 11:38 AM, the QIDP said during an interview that the clients would be relocated to another facility that had a natural gas generator in the event of an emergency or power outage. When asked if there were written policies and procedures outlined in the EP to maintain the aforementioned systems the QIDP said "the policies and procedures are in the process of being developed". At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed fire detection, extinguishing and alarm systems, sewage and waste disposal during emergency situations.	E 015		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,	E 018	E 018 Tracking procedures for staff and people supported are outlined in the policy for emergency/disaster situations (submitted with this document) but a separate policy was developed. By...4-6-18	

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E 018	Continued From page 6	E 018		

and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:]

(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

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

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E 018	Continued From page 7 must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures to track the location of staff and sheltered clients during an emergency, for five (5) of 5 clients residing in the facility. (Clients #1, 2, 3,4 and 5) Findings included: On 03/06/18, at 8:42 AM, the QIDP was asked about the facility's method of tracking the location(s) of staff and sheltered clients during an evacuation. The QIDP 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	E 018		

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	09G071	A. BUILDING _____ B. WING _____	03/08/2018

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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 018		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.475(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].	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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E 022	Continued From page 9	E 022		

*[For Inpatient Hospices at §418.113(b):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(i) A means to shelter in place for patients, hospice employees who remain in the hospice.
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to develop policies and procedures that address a means of sheltering in place for clients and staff who remain in the facility during a disaster or emergency situations, for five (5) of 5 clients residing in the facility. (Clients #1, 2, 3, 4 and 5)

Findings included:

On 03/08/18, beginning at 11:34 AM, review of the facility's EPP, dated 11/21/17, showed no evidence that the facility had developed policies and procedures to address sheltering in place for clients and staff.

On 03/08/18, at 11:48 AM, the QIDP said during an interview that staff had been trained on what to do should staff and clients have to shelter in place for tornados, active shooter, hurricane, etc. When asked if there were policies and procedures outlined in the EP for in sheltering place that was aligned with the facility's risk assessment, the QIDP responded by saying, "the policies and procedures are in the process of being developed".

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

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E 022	Continued From page 10 procedures that the EP addressed sheltering in place during emergencies and disasters.	E 022		
E 023	Policies/Procedures for Medical Documentation CFR(s): 483.475(b)(5) [(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:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and	E 023	E023 The medical documentation policy was developed by 4-6-18. It should be noted that a copy of each person's Health Passport is a part of the emergency bag for each person that is taken with them in an emergency situation as will be reflected in the policy.	

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E 023	Continued From page 11 secures and maintains the availability of records. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures that address a system that protects the confidentiality of client information during an emergency, for five (5) of 5 clients residing in the facility. (Clients #1, 2, 3, 4 and 5) Findings included: On 03/08/18, at 11:34 AM, review of the EP dated 11/21/17, showed no evidence that a policy and procedure had been developed that outlined a medical record documentation system that preserved that the clients information, protested confidentiality of client information and secured and maintained availability of records during an emergency. On 03/08/2018, at 11:51 AM, the QIDP said during an interview that there was no policies and procedures that outlined a medical record documentation system that preserved client information. The QIDP said that the facility was in the process of developing the aforementioned policies and procedures. At the time of the survey, there was no evidence that the facility developed policies and procedures that addressed ensuring the confidentiality of client information.	E 023		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 024		

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E 024	Continued From page 12 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:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures that address the use of volunteers during an emergency, for five (5) of 5 clients residing in the facility. (Clients #1, 2, 3, 4 and 5) Findings included: On 03/08/18, at 02/01/18, at 11:34 AM, review of the facility's EP, dated 11/21/17 showed no evidence that policies and procedures had been developed to address how and if the facility would use volunteers during emergencies. 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	E 024	E 024 The emergency staffing protocol was developed by...4-6-18 It should be noted that BRA does not plan to use volunteers as will be reflected in the protocol. BRA has prepared an agreement document with nearby Providence Hospital that will provide emergency support for people who need it in an emergency situation. BRA as does many in the provider community, already has a working relationship with Providence. The agreement will be presented by...4-23-18. BRA will complete the memorandum of understanding for the local hotels used and for the hotels that are at least 25 miles away and submit them to the appropriate hotel personnel to be signed by...4-23-18 Before presenting the documents to the hotel, BRA will submit them to licensing for review and comment.	

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E 025	Continued From page 15 At the time of the survey, there was no evidence that the facility's EP included written procedures to follow if the clients must relocate during an emergency.	E 025		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures that describe its role in providing care in accordance with section 1135 of the Stafford Act, during a major disaster or federal emergency, for five (5)	E 026	E 026 The emergency/disaster policy submitted with these survey responses outline BRA support parameters during hotel stays based on emergency situations. BRA also provides support staff during hospital stays and the agreement with Providence will reflect that...4-6-18 BRA's intend is to provide staff support wherever services are being rendered in an emergency situation.	

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E 026 Continued From page 16

of 5 clients residing in the facility. (Clients #1, 2, 3, 4 and 5)

Findings included:

On 03/08/18, beginning at 11:43 AM, review of the facility's EPP, dated 11/21/17 showed no evidence that the facility had developed policies and procedures to address the facility's role in providing care and treatment at alternative care sites under the 1135 waiver.

On 03/06/18, at 10:39 PM, the QIDP said during an interview that the facility and its governing body had not developed policies and procedures outlining the facility's role in emergencies declared by the Secretary of Health and Human Services or when the President declares a major disaster or emergency under the Stafford Act.

At the time of the survey, there was no evidence that the facility's EPP addressed the provision of care at alternate sites during national emergencies.

E 026

E 033 Methods for Sharing Information
CFR(s): 483.475(c)(4)-(6)

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

(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.

E 033

E033

The method of sharing medical information is outlined in the BRA COOP and will be outlined in a specific protocol by...4-6-18
As mentioned, a copy of the Health Passport is included in the emergency supply bag for each person supported as is a copy of their PEPP. This will be mentioned in the protocol.
This consideration will be outlined in the Communications plan to be developed by 4-23-18.

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(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to develop written policies that addressed the means the facility would use to release client information to include the general condition and location of clients, 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 11:34 AM, review of the facility's EP dated 11/21/17, showed no evidence of written policies to ensure the

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E 033	Continued From page 18 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 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 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 clients during an emergency.	E 033		
E 034	Information on Occupancy/Needs CFR(s): 483.475(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 034	E034 The Communications Plan is attached for review by...4-6-18	

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E 034	Continued From page 19 *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on record review and interview, the facility's communication plan failed to have a method for providing information about the facility's occupancy to the authority having jurisdiction, 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 evidence of a means for providing information about the facility's occupancy to the authority having jurisdiction during an emergency. On 03/08/18, at 12:15 PM, the QIDP said that the communication plan was in the process of being updated to address the status of clients in the facility, and the facility's ability to provide care during an emergency. At the time of the survey, there was no evidence that the facility's communication plan addressed the release of information to include the general condition and location of clients during an emergency.	E 034		

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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 prioritized 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.	

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E 035	Continued From page 21 via e-mail. 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.	E 035		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024	Continued From page 13 situations. When asked if there were policies and procedures related to volunteers in the EPP, the QIDP responded by saying, "the policies had not been developed". At the time of the survey, there was no evidence that the facility's EP addressed the use of volunteers during emergencies.	E 024		
E 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) [(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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of	E 025	E 025 BRA has prepared an agreement document with other providers who will partner and provide emergency support for people who need it in an emergency situation. BRA as does many in the provider community, already has a working relationship with other providers. ...4-6-18. BRA will complete the memorandum of understanding for the for partner with other agencies during emergency situations by...4-23-18 Before presenting the documents to the hotel, BRA will submit them to licensing for review and comment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G071	A. BUILDING _____ B. WING _____	03/08/2018

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E 025	Continued From page 14 operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop written policies and procedures that address arrangements and/or agreements the facility had with other facilities or other entities during an emergency, for five (5) of 5 clients residing in the facility. (Clients #1, 2, 3, 4 and 5) Findings included: On 03/06/18, at 8:32 AM, the QIDP said during the initial interview that in the event clients have to be evacuated, the clients would be relocated to another sister facility or hotel. The QIDP also said the clients could relocate to the main corporate office located in the district that could accommodate of the needs of the clients. On 03/08/18, beginning at 11:55 AM, review of the facility's EP, dated 11/21/17, showed no evidence that policies and procedures had been developed to address arrangements and/or agreements the made with other outside entities during an emergency. On 03/08/18, at 12:05 PM, the QIDP said during an interview that the facility had not obtained a memorandum of understanding with any hotel(s) in the event that the facility had to be evacuated.	E 025		