	RTMENT OF HEALTH			100	RINTED: 01/04/2019 FORM APPROVED
	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T/VO) MILITER	PLE CONSTRUCTION &	MB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
		09G055	B. WING		12/21/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	,
BEHAVIOR RESEARCH ASSOCIATES				WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W 000	INITIAL COMMENT	S	W 000		
	12/18/18 through 12 selected from a pop woman with intellect person, Client #3, w review of the client's needs. This survey focused fundamental The findings of the s	survey were based on ews and review of client and			
	appear throughout the 1:1 - One to One DSP - Direct Support POS - Physician's Order of Post - Physician order of Post - Post - Physician of Post - Post - Physician of Post - Post - Physician of Physician	t Professional rder Sheets ellectual Disabilities se ROGRAM 1) vide each employee with training that enables the his or her duties effectively, etently.	W 189	The QIDP will re-train all staff on reporting any repair issues for all a and assistive equipment and on completing the adaptive equipment checklist form daily1-10-19 The Home Manager will also be train this issues and their role in followp1-10-19	t
	DIRECTOR'S OR PROVIDER	R'SUPPLIER REPRESENTATIVE'S SIGNA	ATURE 3	untre TITLE QIPD	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

PRINTED: 01/04/2019 FORM APPROVED OMB NO. 0938-0391

OLIVIL	THE PROPERTY OF THE	& MEDICAID SERVICES			MB NO. 0938-03	91
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G055	B. WING		12/21/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
BEHAVI	OR RESEARCH ASSO	CIATES	1	WASHINGTON, DC 20019	** *	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIO	IN
W 189	Findings included: On 12/21/18 at 10:0 #1's bathroom reveal chair. One of the forwas not attached to used to secure the lashower. The QIDP a shower chair leg with unsuccessful. During the observation of the form direct supports are ported that the leg broken. Further discept of the form direct support are ported that all monitor adaptive equiperort any needed reconducted a training agenda/sign. The form showed the conducted a training Client #1's fall protoc the facility's Adaptive Instructions for reviet that: Any staff membinerson is responsible problems When a member will (1) Docton the adaptive equiperson the adaptive equiperson the staff of the problems	O AM, observation of Client aled it included a shower ar legs of the shower chair the chair. The two pieces eg were also observed in the attempted to secure the high the two pieces, but was on, the QIDP stated that a supervision 24 hours a day staff, however no staff had on the shower chair was ussion with the QIDP at 2:12 staff was trained to use and aipment, and to immediately epairs. PM, the QIDP provided a lature form dated 05/20/18. The QIDP and the RN on adaptive equipment and sol. The QIDP also provided a Equipment Checklist w. The checklist showed er working with a supported of for reporting any identified problem is identified the staff ument identified problem(s) oment form. (2) Give	W 189	The House Manager will review adaptive equipment checklist data minimum weekly and will conduct verification audit to confirm that the entered accurately reflects the corof all adaptive and supportive equipment. Should the Manager frany equipment to have repair issure reported or documented by staff, appropriate follow up action will be implemented with the responsible member1-10-19 Once reported, it is the responsible member1-10-19 Once reported, it is the responsible to the QIDP and RN working collaboratively to ensure that reparand/or replacement issues are addressed in a timely manner. In cases, the status of follow up is reviewed at minimum weekly during management team meetings until issue is resolved1-10-19 The IMC will continue to monitor adaptive equipment monthly and in the status of all equipment in personal specific fashion to DDS1-5-19 BRA had a replacement shower costorage that has been retrieved and status of all equipment in personal specific fashion to DDS1-5-19	the a at a a e data ndition ind les not e staff fility of air such ag the all report on- hair is and is	
	person is responsible problems When a member will (1) Docton the adaptive equipadaptive equipment (3) The house manager	e for reporting any identified problem is identified the staff ument identified problem(s) oment form. (2) Give form to the house manager ger will notify the adaptive or and hand deliver or fax the		BRA had a replacement shower c	nd is	

At the time of the survey, the facility failed to

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY MPLETED
		09G055	B. WING		12	2/21/2018
NAME OF	PROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CO		
BEHAVI	OR RESEARCH ASSO	CIATES	1	WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 189	provide ongoing sta demonstrate compe the condition of Clie SPACE AND EQUIF	off training for each staff to etency to monitor and report ent #1's shower chair.	W 189			
	and teach clients to choices about the u hearing and other c and other devices in	nish, maintain in good repair, use and to make informed se of dentures, eyeglasses, ommunications aids, braces,			(*) *	
	Based on observati review, the facility fa equipment (a shower	onot met as evidenced by: on, interview and record hiled to ensure adaptive er chair) was maintained in of two clients of the sample				
	Findings included: The facility failed to client #1's shower cevidenced below:	ensure one of four legs on hair was secured in place, as		BRA had a replacement sho is storage that has been reti is now being used to support when bathing1-1-19	rieved and	
	Client #1 in a wheeld the main bathroom (second DSP squeez the bathroom to assi client during toileting Client #1 required 1: by direct support star	ng at 8:22 AM, a DSP rolled chair through the doorway of located off the hallway). A sed through the doorway of st the other DSP and the . The QIDP stated that 1 supervision 24 hours a day ff for active engagement, and vities of daily living, including				

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY MPLETED
		09G055	B. WING _	_	12/	21/2018
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE WASHINGTON, DC 20019	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 436	#1's master bathrood shower. Additionall with one of the four stated that the show client, and attempted pieces of the leg, however chair was behad reported the brown on 12/21/18 at 11:4 POS for December adaptive equipment.	20 AM, observation of Client om showed it included a y, there was a shower chair legs missing. The QIDP wer chair belonged to the od to secure the detached owever, she was QIDP acknowledged that the roken, and stated that no staff oken leg. 2 AM, review of Client 1's 2018 showed the prescribed included a shower chair.	W 436	The House Manager will review adaptive equipment checklist da minimum weekly and will conduct verification audit to confirm that data entered accurately reflects condition of all adaptive and sup equipment. Should the Manager any equipment to have repair iss not reported or documented by a appropriate follow up action will implemented with the responsiblemember1-10-19 Once reported, it is the responsite the QIDP and RN working collaboratively to ensure that repand/or replacement issues are addressed in a timely manner. In cases, the status of follow up is reviewed at minimum weekly dumanagement team meetings untissue is resolved1-10-19 The IMC will continue to monitor adaptive equipment monthly and the status of all equipment in perspecific fashion to DDS1-5-19	ta at tt a the the the portive find sues staff, oe e staff oility of air such ring il the all report	

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING HFD03-0084 12/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BEHAVIOR RESEARCH ASSOCIATES WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 1000 INITIAL COMMENTS 1000 A licensure survey was conducted from 12/18/18 through 12/21/18. Two residents were selected from a population of three men and one woman with intellectual disabilities. A third person. Resident #3, was added for a focused review of the resident's self-medication training needs. 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. 1:1 - One to One DSP - Direct Support Professional POS - Physician's Order Sheets QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse 1090 3504.1 HOUSEKEEPING 1090 1. The open area identified has been properly filled and the potential trip The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, hazard has been abated...1-1-19 and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable 2. The standing water has been drained odors. and the drain has been snaked out to prevent future clogging...1-1-19 This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to ensure the environment was maintained in accordance with the needs of four of four residents of the facility (Residents #1, 2, 3 and 4). Findings included:

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

On 12/20/18 beginning at 9:20 AM, the QIDP, the

TITLE

(X6) DATE

PRINTED: 01/04/2019 FORM APPROVED

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING HFD03-0084 12/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) 1 090 Continued From page 1 1090 incident manager, and the maintenance . The baseboard will be repaired and coordinator accompanied the surveyor to conduct the drain line will be lengthened to an observation of the environment. The following ensure water flows away from the concerns were identified: foundation of the building. These repairs will be completed by...1-8-19 1. There was an open area in the asphalt pavement leading down to the basement. This BRA maintains a full-time maintenance area was directly on the left side of the first step staff member that makes repairs and and created a potential trip hazard. coordinates with contractors for skilled work. The maintenance staff member 2. There was standing water in the drain located will be charged going forward with outside the basement door. The water was reviewing each service location using approximately three inches below the drain cover and created the potential for flooding or the an environmental audit tool and basement during heavy rain. reporting any issues found to the President and Vice President for timely The baseboard was damp and rotting along the follow up. The tool also requires the wall where the sump pump was located in the Maintenance Staff person to identify the linen room. On the exterior of the facility, the action steps needed to address any . drain line from the sump pump was very short, issue found. The Vice President will which prevented the water from flowing away review the tool and the process with the from the foundation of the building. Maintenance Staff person and follow up will begin...1-10-19 On 12/21/18 at 2:33 PM, the maintenance coordinator indicated that repairs were underway. At the time of the survey, the facility failed to ensure that the interior and exterior of the GHIID was maintained 1222 3510.3 STAFF TRAINING 1222 There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to provide each staff with ongoing training to monitor and report the

Health Regulation & Licensing Administration

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	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION 3:		SURVEY PLET E D
		HFD03-0084	B. WING	 1	12/	21/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY,	STATE, ZIP CODE	-	
BEHAVIOR RESEARCH ASSOCIATES			GTON, DC 2	20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
1 222	2 Continued From pa	age 2	1 222			
	condition of adaptive for one of two reside #1).	ve equipment (shower chair) dents in the sample (Resident				
	Findings included:				: # 5	
	Resident #1's bathme shower chair. One of chair was not attach pieces used to secur in the shower. The of shower chair leg with unsuccessful. During the observate Resident #1 received day from direct supplied that the broken. Further discipled monitor adaptive equal to the chair content of the chair content with the chair content of the chair content of the chair content of the chair content of the chair	On 12/21/18 at 10:00 AM, observation of Resident #1's bathroom revealed it included a shower chair. One of the four legs of the shower chair was not attached to the chair. The two bieces used to secure the leg were also observed in the shower. The QIDP attempted to secure the shower chair leg with the two pieces, but was unsuccessful. Ouring the observation, the QIDP stated that Resident #1 received 1:1 supervision 24 hours a lay from direct support staff, however no staff and reported that the leg on the shower chair was proken. Further discussion with the QIDP at 2:12 PM indicated that all staff was trained to use and monitor adaptive equipment, and to immediately eport any needed repairs.		The QIDP will re-train all staff or reporting any repair issues for a adaptive and assistive equipme on completing the adaptive equipment checklist form daily. 19 The Home Manager will also be trained on this issues and their follow up1-10-19	all ent and 1-10-	
	training agenda/sign The form showed th conducted a training Resident #1's fall pro- provided the facility's Checklist Instruction showed that: Any sta supported person is identified problems identified the staff m identified problem(s) form. (2) Give adapti house manager. (3)	7 PM, the QIDP provided a nature form dated 05/20/18. hat the QIDP and the RN g on adaptive equipment and rotocol. The QIDP also 's Adaptive Equipment ns for review. The checklist taff member working with a s responsible for reporting any When a problem is nember will (1) Document s) on the adaptive equipment tive equipment form to the The house manager will equipment coordinator and			· ·	

hand deliver or fax the adaptive equipment

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FORM APPROVED Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING_ HFD03-0084 12/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1 222 Continued From page 3 1222 checklist. At the time of the survey, the facility failed to provide ongoing staff training for each staff to demonstrate competency to monitor and report the condition of Resident #1's shower chair.

Health Regulation & Licensing Administration

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TATEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	O. 0938-03 ATE SURVEY
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		09G055	B. WING		12	2/21/2018
	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP		
DENAVI	OR RESEARCH ASSO		WA	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000		A.02	
	An emergency prep conducted from 12/	paredness survey was 18/18 through 12/21/18.				
	The findings of the sinterviews and review preparedness progra	survey were based on w of the emergency am.				
	Note: The below are appear throughout the	e abbreviations that may ne body of this report.				
	CP - Communication DSP - Direct Suppor EP - Emergency Plan	t Professional				
	EPP - Emergency Pr ISP - Individual Supp QIDP - Qualified Inte Professional	reparedness Program			.≢ā [©]	
E 009	A - 19/2/14 A TOTAL TOTAL TOTAL TOTAL TOTAL A - 1	ollaboration Process 4)	E 009			
	and maintain an eme	The [facility] must develop organized preparedness plan d, and updated at least ust do the following:]				
t c s	Federal emergency po to maintain an integra disaster or emergenc documentation of the such officials and, wh	al, tribal, regional, State, and reparedness officials' efforts ated response during a y situation, including facility's efforts to contact			ger te	
+ Ir	[For ESRD facilities notude a process for	only at §494.62(a)(4)]: (4) cooperation and				

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.

DEPARTMENT OF HEALTH AND HU'N SERVICES CENTERS FOR MEDICARE & MEDIC, JD SERVICES

PRINTED: 12/28/2018 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		TE SURVEY
		09G055	B. WING		1 12	2/21/2018
NAME OF	PROVIDER OR SUPPLIER	•	s	STREET ADDRESS, CITY, STATE, ZIP CODE		112010
BEHAV	OR RESEARCH ASSO	CIATES	V	VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(X5) COMPLETION DATE
	collaboration with lot Federal emergency to maintain an integration of the contact such official participation in collar planning efforts. The the local emergency least annually to corof the dialysis facility emergency. This STANDARD is Based on the review with the EP leader (show documentation process for ensuring collaboration with local emergency process for ensuring and integral disaster or emergency process for ensuring in the disaster or emergency process for ensuring in the disaster or emergency process for emergency process for ensuring in the disaster or emergency process for ensu	pical, tribal, regional, State, and preparedness officials' efforts trated response during a necy situation, including the dialysis facility's efforts to and, when applicable, of its aborative and cooperative edialysis facility must contact a preparedness agency at a firm that the agency is aware and interview of documents and interview QIDP), the facility failed to an of efforts relevant to the accoperation and cal, regional, state and preparedness officials' efforts the disconse during a cooperation, for four of four effacility (Clients #1, 2, 3 and the QIDP stated that the in conversations with local and the preparedness program ficials indicated a willingness staff.	E 009	The Emergency preparedness policies will be updated to clearl outline the process for collabora with local, state and federal age on emergency situations1-10-BRA will also contact these age to set up an all facilities emerge drill scenario to be undertaken vill scenario to be	nting ncies -19 ncies ncy,	

DEPARTMENT OF HEALTH AND HI' AN SERVICES PRINTED: 12/28/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDIC. ID 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 09G055 B. WING 12/21/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BEHAVIOR RESEARCH ASSOCIATES** WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 009 | Continued From page 2 E 009 develop a collaborative approach to responding to disasters and other emergency situations with local, regional, state and federal emergency preparedness officials. When interviewed again on 12/21/18 at 1:30 PM, the QIDP replied "no" when asked if the facility had engaged in any collaborative planning efforts with local, state or federal emergency preparedness officials. She stated that she was surprised that the email in which an assistant fire chief expressed a willingness to provide training for facility staff was not in the EPP binder. She acknowledged that to date, the facility had not followed up with the fire department and there was no written policy regarding collaborating with regional emergency preparedness officials. 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 emergency preparedness officials' efforts to ensure an integrated response during a disaster. E 035 LTC and ICF/IID Sharing Plan with Patients E 035 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

families or representatives.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		09G055	B. WING_		12	/21/2018
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	121/2016
BEHAVIOR RESEARCH ASSOCIATES			WASHINGTON, DC 20019	88		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE
	Based on interview emergency manage documentation, the procedures regarding information regarding involved family memore four of four clients reference with a support when the teas shared with each clies shared with each clies shared with each clies support when the teas ISP. In addition, she electronically to familiattorneys in August 2 that the CP included the EP was to be shared with EP was to be shared with exidence of written produced the teast on how into would be shared with family members and/or inder contained a proper shared with family members and/or inder contained a proper shared with family members and/or inder contained a proper shared with family members and/or inder contained a proper shared with family members and/or inder contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or index contained a proper shared with family members and/or ind	and review of the facility's and the program CP failed to include written ag how the facility will share go the EP with clients and their abers and/or guardians, for a siding in the facility (Clients). PM, interview with the QIDP of the facility's EP had been and his or her circle of am met to review the client's had sent copies of the EP by members, guardians and 2018. The QIDP also stated instructions regarding how ared with clients and their pers and/or guardians.	E 03	The QA Consultant and QIDP wis collaborate to modify the emerge policy to reflect clear procedures sharing information with the peopsupported, their involved family, guardians and other representating As indicated by the QIDP, this wis primarily be implemented during team meetings but there will be a process outlined for providing information when changes occur during the ISP year and/or prograyear1-20-19	ency for ole legal ves. ill ISP	

PRINTED: 12/28/2018 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC, SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 09G055 B. WING 12/21/2018 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 035 Continued From page 4 E 035 include written procedures regarding how the EP would be shared with clients and their family/guardians. She stated "I will update that ... put it in there." She repeated that it was the facility's practice to distribute copies of the EP before each client's ISP meeting and discuss the EP at the ISP meeting. At the time of the survey, the CP failed to outline written procedures regarding the sharing of EP related information with clients and their family/guardians.