STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G055	A. BUILDING _____ B. WING _____	12/21/2018

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 12/18/18 through 12/21/18. Two clients were selected from a population of three men and one woman with intellectual disabilities. A third person, Client #3, was added for a focused review of the client's self-medication training needs. This survey was conducted using the focused fundamental survey process. The findings of the survey were based on observations, interviews and review of client and administrative records. Note: The below are abbreviations that may appear throughout the body of this report. 1:1 - One to One DSP - Direct Support Professional POS - Physician's Order Sheets QIDP - Qualified Intellectual Disabilities Professional RN - Registered Nurse	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide each staff with ongoing training to monitor and report the condition of adaptive equipment (shower chair) for one of two clients in the sample (Client #1).	W 189	The QIDP will re-train all staff on reporting any repair issues for all adaptive and assistive equipment and on completing the adaptive equipment checklist form daily…1-10-19 The Home Manager will also be trained on this issues and their role in follow up…1-10-19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIPD (X6) DATE 1/7/19

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

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W 189	Continued From page 1 Findings included: On 12/21/18 at 10:00 AM, observation of Client #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 pieces 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. During the observation, the QIDP stated that Client #1 received 1:1 supervision 24 hours a day from direct support staff, however no staff had reported that the leg on the shower chair was broken. Further discussion with the QIDP at 2:12 PM indicated that all staff was trained to use and monitor adaptive equipment, and to immediately report any needed repairs. On 12/21/18 at 2:37 PM, the QIDP provided a training agenda/signature form dated 05/20/18. The form showed that the QIDP and the RN conducted a training on adaptive equipment and Client #1's fall protocol. The QIDP also provided the facility's Adaptive Equipment Checklist Instructions for review. The checklist showed that: Any staff member working with a supported person is responsible for reporting any identified problems... When a problem is identified the staff member will (1) Document identified problem(s) on the adaptive equipment form. (2) Give adaptive equipment form to the house manager. (3) The house manager will notify the adaptive equipment coordinator and hand deliver or fax the adaptive equipment checklist. At the time of the survey, the facility failed to	W 189	The House Manager will review the adaptive equipment checklist data at minimum weekly and will conduct a verification audit to confirm that the data entered accurately reflects the condition of all adaptive and supportive equipment. Should the Manager find any equipment to have repair issues not reported or documented by staff, appropriate follow up action will be implemented with the responsible staff member...1-10-19 Once reported, it is the responsibility of the QIDP and RN working collaboratively to ensure that repair and/or replacement issues are addressed in a timely manner. In such cases, the status of follow up is reviewed at minimum weekly during management team meetings until the issue is resolved...1-10-19 The IMC will continue to monitor all adaptive equipment monthly and report the status of all equipment in person-specific fashion to DDS...1-5-19 BRA had a replacement shower chair is storage that has been retrieved and is now being used to support Client #1 when bathing...1-1-19	

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W 189	Continued From page 2 provide ongoing staff training for each staff to demonstrate competency to monitor and report the condition of Client #1's shower chair.	W 189		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adaptive equipment (a shower chair) was maintained in good repair for one of two clients of the sample (Client #1). Findings included: The facility failed to ensure one of four legs on Client #1's shower chair was secured in place, as evidenced below: On 12/19/18 beginning at 8:22 AM, a DSP rolled Client #1 in a wheelchair through the doorway of the main bathroom (located off the hallway). A second DSP squeezed through the doorway of the bathroom to assist the other DSP and the client during toileting. The QIDP stated that Client #1 required 1:1 supervision 24 hours a day by direct support staff for active engagement, and for safety during activities of daily living, including toileting and bathing.	W 436	BRA had a replacement shower chair is storage that has been retrieved and is now being used to support Client #1 when bathing...1-1-19	

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W 436	Continued From page 3 On 12/21/18 at 10:00 AM, observation of Client #1's master bathroom showed it included a shower. Additionally, there was a shower chair with one of the four legs missing. The QIDP stated that the shower chair belonged to the client, and attempted to secure the detached pieces of the leg, however, she was unsuccessful. The QIDP acknowledged that the shower chair was broken, and stated that no staff had reported the broken leg. On 12/21/18 at 11:42 AM, review of Client 1's POS for December 2018 showed the prescribed adaptive equipment included a shower chair. At the time of the survey, the facility failed to ensure that Client #1's prescribed shower chair was maintained in good repair.	W 436	The House Manager will review the adaptive equipment checklist data at minimum weekly and will conduct a verification audit to confirm that the data entered accurately reflects the condition of all adaptive and supportive equipment. Should the Manager find any equipment to have repair issues not reported or documented by staff, appropriate follow up action will be implemented with the responsible staff member…1-10-19 Once reported, it is the responsibility of the QIDP and RN working collaboratively to ensure that repair and/or replacement issues are addressed in a timely manner. In such cases, the status of follow up is reviewed at minimum weekly during management team meetings until the issue is resolved…1-10-19 The IMC will continue to monitor all adaptive equipment monthly and report the status of all equipment in person-specific fashion to DDS…1-5-19	

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS 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	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. 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: On 12/20/18 beginning at 9:20 AM, the QIDP, the	I 090	1. The open area identified has been properly filled and the potential trip hazard has been abated…1-1-19 2. The standing water has been drained and the drain has been snaked out to prevent future clogging…1-1-19	

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I 090	Continued From page 1 incident manager, and the maintenance coordinator accompanied the surveyor to conduct an observation of the environment. The following concerns were identified: 1. There was an open area in the asphalt pavement leading down to the basement. This area was directly on the left side of the first step and created a potential trip hazard. 2. There was standing water in the drain located outside the basement door. The water was approximately three inches below the drain cover and created the potential for flooding or the basement during heavy rain. 3. The baseboard was damp and rotting along the wall where the sump pump was located in the linen room. On the exterior of the facility, the drain line from the sump pump was very short, which prevented the water from flowing away from the foundation of the building. 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.	I 090	. The baseboard will be repaired and the drain line will be lengthened to ensure water flows away from the foundation of the building. These repairs will be completed by...1-8-19 BRA maintains a full-time maintenance staff member that makes repairs and coordinates with contractors for skilled work. The maintenance staff member will be charged going forward with reviewing each service location using an environmental audit tool and reporting any issues found to the President and Vice President for timely follow up. The tool also requires the Maintenance Staff person to identify the action steps needed to address any issue found. The Vice President will review the tool and the process with the Maintenance Staff person and follow up will begin...1-10-19	
I 222	3510.3 STAFF TRAINING 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	I 222		

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I 222	Continued From page 2 condition of adaptive equipment (shower chair) for one of two residents in the sample (Resident #1). Findings included: 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 pieces 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. During the observation, the QIDP stated that Resident #1 received 1:1 supervision 24 hours a day from direct support staff, however no staff had reported that the leg on the shower chair was broken. Further discussion with the QIDP at 2:12 PM indicated that all staff was trained to use and monitor adaptive equipment, and to immediately report any needed repairs. On 12/21/18 at 2:37 PM, the QIDP provided a training agenda/signature form dated 05/20/18. The form showed that the QIDP and the RN conducted a training on adaptive equipment and Resident #1's fall protocol. The QIDP also provided the facility's Adaptive Equipment Checklist Instructions for review. The checklist showed that: Any staff member working with a supported person is responsible for reporting any identified problems... When a problem is identified the staff member will (1) Document identified problem(s) on the adaptive equipment form. (2) Give adaptive equipment form to the house manager. (3) The house manager will notify the adaptive equipment coordinator and hand deliver or fax the adaptive equipment	I 222	The QIDP will re-train all staff on reporting any repair issues for all adaptive and assistive equipment and on completing the adaptive equipment checklist form daily…1-10-19 The Home Manager will also be trained on this issues and their role in follow up…1-10-19	

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I 222	Continued From page 3 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.	I 222		

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E 000	Initial Comments An emergency preparedness survey was conducted from 12/18/18 through 12/21/18. The findings of the survey were based on interviews and review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. CP - Communication Plan DSP - Direct Support Professional EP - Emergency Plan EPP - Emergency Preparedness Program ISP - Individual Support Plan QIDP - Qualified Intellectual Disabilities Professional	E 000		
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	E 009		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE QIDP (X6) DATE 1-9-19

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

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E 009	Continued From page 1 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 the review of documents and interview with the EP leader (QIDP), the facility failed to show documentation of efforts relevant to the process for ensuring cooperation and collaboration with local, regional, state and federal emergency preparedness officials' efforts to ensure an integrated response during a disaster or emergency situation, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: When interviewed in the facility on 12/20/18 beginning at 3:29 PM, the QIDP stated that the facility had engaged in conversations with local fire and rescue persons. They had shared a copy of the facility's emergency preparedness program (EPP) and the fire officials indicated a willingness to provide training for staff. On 12/21/18 beginning at 9:39 AM, review of the facility's EPP (dated "2018") showed no documentation showing contacts with the fire department and no evidence of policies and procedures regarding how the facility would	E 009	The Emergency preparedness policies will be updated to clearly outline the process for collaborating with local, state and federal agencies on emergency situations...1-10-19 BRA will also contact these agencies to set up an all facilities emergency, drill scenario to be undertaken within 60 days if feasible as confirmed by the relevant agencies...1-20-19	

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E 009	Continued From page 2 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 009		
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.	E 035		

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E 035	Continued From page 3 This STANDARD is not met as evidenced by: Based on interview and review of the facility's emergency management program documentation, the CP failed to include written procedures regarding how the facility will share information regarding the EP with clients and their involved family members and/or guardians, for four of four clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: On 12/20/18 at 3:50 PM, interview with the QIDP revealed that copies of the facility's EP had been shared with each client and his or her circle of support when the team met to review the client's ISP. In addition, she had sent copies of the EP electronically to family members, guardians and attorneys in August 2018. The QIDP also stated that the CP included instructions regarding how the EP was to be shared with clients and their involved family members and/or guardians. On 12/21/18 beginning at 9:39 AM, review of the facility's EPP (dated "2018") revealed no evidence of written policies and procedures to direct staff on how information regarding the EP would be shared with clients and their involved family members and/or guardians. The EPP binder contained a printed hard copy of an email that the QIDP sent to clients' families, attorneys and guardians on 08/30/18 inviting them to attend a training on the EPP being offered at the facility in September 2018. The EP had been attached to the 08/30/18 email. During a follow-up interview on 12/21/18 at 1:42 PM, the QIDP reviewed the EP and confirmed that the current policies and procedures did not	E 035	The QA Consultant and QIDP will collaborate to modify the emergency policy to reflect clear procedures for sharing information with the people supported, their involved family, legal guardians and other representatives. As indicated by the QIDP, this will primarily be implemented during ISP team meetings but there will be a process outlined for providing information when changes occur during the ISP year and/or program year…1-20-19	

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E 035	Continued From page 4 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.	E 035		