| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G118 | A. BUILDING _____ B. WING _____ | 10/25/2018 |

| 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<br><br>An initial certification survey was conducted from 10/23/18 through 10/25/18. A sample of three clients was selected from a population of five males with varying degrees of intellectual disabilities. This survey was conducted utilizing the full survey process.<br><br>The findings of the survey were based on observations, interviews and review of client and administrative records.<br><br>The survey findings determined that the facility was in substantial compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities. No deficiencies were cited. | W 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G118 | A. BUILDING _____ B. WING _____ | 10/25/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BEHAVIOR RESEARCH ASSOCIATES | [redacted] WASHINGTON, DC 20019 |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An emergency preparedness survey was conducted from 10/23/18 through 10/25/18.<br><br>The facility was in substantial compliance with the requirements of Emergency Preparedness Requirements for Medicare and Medicaid Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).<br><br>No deficiencies were cited. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

Health Regulation & Licensing Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HFD03-0079 | A. BUILDING: _____ B. WING _____ | 10/25/2018 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| I 000 | INITIAL COMMENTS<br><br>A full licensure survey was conducted from 10/23/18 through 10/25/18. A sample of three residents was selected from a population of fives males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews, and reviews of resident and administrative records.<br><br>The survey findings determined that the facility was in substantial compliance with the requirements of Title 22 Public Health and Medicine Chapter 35 Group Homes for Individuals with Intellectual Disabilities.<br>No deficiencies were cited. | I 000 | | |