PRINTED: 06/08/2011
FORM APPROVED
OMB NO. 0938-0391

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

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 _____	05/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	5051 LEE STREET NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from May 10, 2011 through May 11, 2011. A sample of three clients was selected from a population of five men with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 6/22/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify guardians of all significant incidents, for two of the five clients residing in the facility. (Clients #2 and #5) The findings include: [Cross-refer to W153] On May 10, 2011, beginning at 8:47 a.m., review of incident reports revealed that on May 29, 2010, Client #2 became physically aggressive during a behavioral episode and hit one of his peers (Client #5) in the face. Further review of the incident report revealed no evidence that Client #5's guardian	W 148	W148 The QDIP and IMC have been re-trained by the Program Director to insure that all appropriate parties are notified about serious reportable incidents that involve their person of interest...6-17-11 Additionally, the Program Director will review each serious reportable incident report prior to submission to insure that they reflect proper notifications...6-17-11 Covered in the aforementioned training as well was the importance of insuring that all aspects of an incident are properly addressed. As mentioned by the surveyor, the incident in questions raised three issues, not just one. Both the QDIP and the IMC clearly understand that at this point based on the surveyor's feedback and follow up feedback by the Program Director and QA Consultant...6-17-11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Reardon — TITLE: President — (X6) DATE: 6/22/11

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 148	Continued From page 1 had been notified of the incident. On May 10, 2011, at 11:08 a.m., interview with the Incident Management Coordinator (IMC) revealed that the Qualified Intellectual Disabilities Professional (QIDP) was responsible for communicating with the clients' families and guardians. When interviewed at 11:35 a.m., the QIDP confirmed that she had not notified Client #5's guardian of the incident. It should be noted that review of staff witness statements revealed that on May 29, 2010, Client #2 alleged that a direct support staff hit him during the behavioral episode. On May 10, 2011, at 11:22 a.m., the QIDP acknowledged that she had not informed Client #2's guardian of his allegation that a staff had hit him. This surveyor left a message on the guardian's answering machine on May 10, 2011, at 12:58 p.m. The guardian, however, did not return the call before the survey ended.	W 148	W153 The IMC will develop a summary report addressing the staff-on-client aspect of the above-mentioned incident...6-17-11. As mentioned by the surveyor, Client #2's behavior program addresses the tendency to make false claims against others. It should also be noted that 3 staff members were present during the incident and observed the interaction between the accused staff member and Client #2. All three were interviewed by the IMC and all three indicated that Client #2 was not hit by the accused staff member. However, there was a failure to document this feedback in writing and develop a simple investigation report to this effect. The training provided to the IMC addressed this consideration and will be monitored by the Program Director for future incidents...6-17-11 In reviewing the incident events with the Facility Administrator, the QIDP did mention Client #2's claim of being hit but did not document this in either a separate incident report or in any other manner. This consideration was addressed in the training provided ...6-17-11 Eye witness testimony on the staff-on-client abuse claim (all who witnessed the interaction contradict Client #2's feedback) and the history of false accusations led the IMC to believe that an incident report and formal follow up investigation was not required. For this reason, no incident report or investigation specific to staff-on-client abuse was sent to DOH. This was an error that was addressed in the training provided. The IMC has been instructed to obtain statements from each staff member and to develop an investigation summary for formal submission...6-17-11. In addition to the factors already mentioned, Client #2 was examined on the spot and there was no physical evidence of being struck.	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of client records, including incident reports and investigations, the facility failed to ensure that all allegations of abuse were reported immediately to the	W 153		

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administrator and the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for one of the five clients residing in the facility. (Client #2)

The finding includes:

1. On May 10, 2011, beginning at 8:47 a.m., review of facility incident reports revealed an incident of client-on-client abuse, dated May 29, 2010. According to the incident report and staff witness statements, Client #2 became physically aggressive during a behavioral episode while out in the community. Client #2's behaviors escalated and he hit one of his peers (Client #5) in the face. According to two staff witness statements that were attached to the corresponding investigation report, also dated May 29, 2010, Client #2 made an allegation that another staff had hit him during the incident. Continued review revealed no reference was made to the allegation of physical abuse by staff in either the original incident report or its corresponding investigation report.

2. Pre-survey review of incidents that were reported to the State agency had not indicated any allegation of staff-on-client abuse. On May 10, 2011, at 10:51 a.m., when asked about the May 29, 2010 incident involving Client #2, the facility's Incident Management Coordinator (IMC) said there had been no incident report prepared specifically about the allegation. Both she and the Qualified Intellectual Disabilities Professional (QIDP), who was present at that time, stated that making false allegations against staff was one of Client #2's known, targeted maladaptive behaviors. The IMC and QIDP further indicated

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that because this was a targeted behavior, Client #2's allegation would only be documented in the client's behavior data. However, on May 11, 2011, at 1:12 p.m., review of Client #2's Behavior Support Plan (BSP) dated November 1, 2009 (updated October 30, 2010), revealed "If <client's name> makes accusations ... that a staff has physically or verbally abused him ...staff should then inform the <QIDP> and supervisory staff of the details of the accusatory incident ...following this, the staff member should document the details of the incident on the data sheet provided. A serious reportable incident should be recorded on an Incident Report Form and reported to the <QIDP> for immediate follow-up.] Facility staff, however, failed to complete an Incident Report form.

3. During the May 10, 2011 interview with the IMC, at 10:53 a.m., she acknowledged that there was no evidence that the facility's administrator had been notified of Client #2's allegation of staff-on-client abuse on May 29, 2010.

Additionally, at the time of the survey, there was no evidence that the aforementioned incident involving Clients #2 and #5 had been reported to the Department of Health.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL — W 159

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record

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review, the facility failed to ensure that each client's active treatment program was monitored by the qualified intellectual disabilities professional (QIDP), for two of the three clients in the sample. (Clients #2 and #3)

The findings include:

1. The QIDP failed to ensure that Client #3's physical therapy (PT) needs were effectively addressed:

a. [Cross-refer to W192] The QIDP failed to ensure that all staff were effectively trained (i.e. demonstrated the skills and competencies needed) to assist Client #3 with negotiating stairs in the facility

It should be noted that on May 11, 2011, at 5:16 p.m., review of Client #3's Fall Prevention protocol, dated October 1, 2010, revealed that it did not reflect the need for two-person assistance while negotiating the stairs. The QIDP acknowledged that the PT had not updated the protocol to reflect his January 18, 2011 re-evaluation and new recommendations.

b. The QIDP failed to ensure that the facility addressed the recommendation to modify the environment to accommodate Client #3's physical safety needs, as evidenced by the following:

On May 11, 2011, beginning at 4:27 p.m., review of Client #3's annual PT assessment, dated January 18, 2011, revealed the recommendation to "Consider installing a ramp in the home over the stairs. The ramp should be foldable and

W159

a. The staff was re-trained by the QIDP to insure that they provide two-person assistance when Client #3 is negotiating stairs...6-12-11

The PT will update the protocol and re-train the staff on the protocol as revised by...6-30-11

b. Ramp installed by...6-30-11

2. CPI training will be conducting for the remaining staff members that need it by...6-30-11.

3. The QIDP will provide additional training on behavior data collection to staff by...6-24-11.

Psychology will provide further training by...7-15-11

The QIDP will systematically track recommendations accepted for each individual on her caseload on a monthly basis to insure follow up is completed in a timely manner...7-1-11

The QA Consultant will periodically audit recommendation follow up and report findings to management for follow up...7-1-11

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W 159	Continued From page 5 removable to allow entry into the washroom ..." to address his decreased ambulating ability. At the time of the survey, there was no ramp in the facility. At 5:18 p.m., the QIDP acknowledged that almost four months had passed since the PT recommended a portable ramp on January 18, 2011. 2. [Cross-refer to W189] The QIDP failed to ensure that staff received training on all facets of behavior intervention, including crisis procedures CPI training. 3. [Cross-refer to W252] The QIDP failed to ensure staff documented all incidents of Client #2's observed targeted behaviors, in accordance with his behavior support plan.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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 staff interview and record review, the facility failed to ensure that staff received training on all facets of behavior intervention, including crisis procedures, for one of the three residents in the sample. (Resident #2) The finding includes: [Cross-refer to W153] On May 10, 2011, beginning at 8:47 a.m., review of incident reports in the facility revealed that on May 29, 2010, staff reported an incident of client-on-client abuse.	W 189	W189 CPI training will be conducting for the remaining staff members that need it by...6-30-11 Any new hires will receive CPI training within their first 90 days and before that will only be allowed to work with staff that have had the training...7-1-11 Refresher training will be implemented at minimum annually...7-1-11	

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The incident report and its corresponding investigation report, also dated May 29, 2010, described how the client's behaviors escalated and he began banging on a van window (glass). A staff "held the client's hand" to prevent him from injuring himself.

On May 10, 2011, at 10:52 a.m., when asked about the May 29, 2010 incident, the facility's incident management coordinator (IMC) and the qualified intellectual disabilities professional (QIDP) said Client #2 had a Behavior Support Plan (BSP) to address numerous maladaptive behaviors, including physical aggression.

On May 11, 2011, at 1:43 p.m., review of Resident #2's BSP, dated November 1, 2009 (updated October 30, 2010) confirmed that the BSP addressed agitation, physical aggression, property destruction and three other target behaviors. The BSP indicated there had been 24 incidents of physical aggression and 53 incidents of property destruction in the preceding year. Further review of the BSP revealed the following: "Only staff trained in <Department on Disability Services> DDS approved crisis prevention techniques may use only the least restrictive crisis prevention techniques to prevent <client's name> from harming himself or others... All staff in the facility should be trained in least restrictive crisis prevention techniques, approved by DDS."

Minutes later, at 1:45 p.m., both the QIDP and IMC indicated that the facility used "CPI, Crisis Prevention Institute" for said training. The QIDP then stated that not all staff were CPI certified. At 2:23 p.m., review of the records presented for CPI training revealed no evidence that eight (8)

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W 189	Continued From page 7 out of thirteen (13) direct support staff, as well as the house manager, had received training in CPI.	W 189		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM 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 observation, interview and record review, the facility failed to ensure that all staff were effectively trained (i.e. demonstrated the skills and competencies needed) to meet the physical support needs of the one client (out of five) that required physical assistance when negotiating stairs. (Client #3) The finding includes: On May 10, 2011, at approximately 7:05 a.m., Client #3 informed the house manager that he needed to use the bathroom. He stood up, took hold of his rolling walker and walked independently to the top of a two-step staircase. The stairs led from the main living area down to the lower level, where the bathrooms were located. The client, who was wearing custom molded orthopedic shoes, placed the walker to his right, held it with his right hand and took hold of a hand railing with his left hand. The house manager stood in front of him, below, while the client lowered himself onto the first step. Client #3 began vocalizing and hesitated. The house manager held the client's upper body and offered instructions and encouragement. The client continued vocalizing and indicated that he was having difficulty. On the second step, the client's	W 192	W192 The staff was re-trained by the QIDP to insure that they provide two-person assistance when Client #3 is negotiating stairs...6-12-11 The PT will update the protocol and re-train the staff on the protocol as revised by...6-30-11	

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knees bent and the house manager gently lowered him to the floor. After verbal encouragement and a pull to his waist, the house manager assisted Client #3 back to his feet and they continued towards the bathroom.

At 8:20 a.m., the qualified intellectual disabilities professional (QIDP) stated that Client #3's health had declined. She acknowledged that the client "does have difficulty" navigating the steps inside the facility.

Later on May 10, 2011, at 4:59 p.m., Client #3 was observed climbing the two steps from the lower level to the main living area. It was a slow process and he complained that his "knees hurt." Two staff provided physical assistance and verbal instructions. At 6:52 a.m., however, the client was observed coming up the steps, with the assistance of only one staff.

Client #3's physical therapy (PT) records were reviewed on May 11, 2011, beginning at 4:16 p.m. His annual PT assessment, dated January 18, 2011, included the following: "Staff were trained on using the <walker> to negotiate the stairs inside the home using two persons ...mobility continues to decline. There is general weakness ... Staff reported increased difficulty negotiating the stairs..."

When interviewed again, on May 11, 2011, at 5:14 p.m., the QIDP stated that she had provided staff in-service training on January 18, 2011 at which time she informed staff that the PT had recommended two-person assistance for Client #3 on the steps while using his walker. She presented a signature sheet of the staff who had

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W 192	Continued From page 9 attended the January 18, 2011 session. When informed that Client #3 was observed negotiating the stairs with one-person assistance, the QIDP said she had provided additional staff training, and presented a signature sheet of an in-service training she had conducted on May 4, 2011. Observations on May 10, 2011, however, indicated that the training had not been effective. It should be noted that at 5:17 p.m., review of Client #3's Fall Prevention protocol, dated October 1, 2010, revealed that the PT had not updated the protocol to reflect his January 18, 2011 recommendations. The QIDP stated that the PT would provide staff in-service training once he updated the client's Fall Prevention protocol.	W 192		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to document all behavior data in accordance with the behavior support plan (BSP), for one of the three clients in the sample. (Client #2) The finding includes: Client #2 was observed in the facility on May 10, 2011, from 4:20 p.m. - 7:17 p.m. During that period, he was observed displaying the following	W 252	W252 The QIDP will provide additional training on behavior data collection to staff by...6-24-11. Psychology will provide further training by...7-15-11	

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behaviors:

- At 5:36 p.m., Client #2 made a sudden jerk motion with his arms while making a grunt sound with his voice (in response to a question from the qualified intellectual disabilities professional -QIDP);

- At 5:45 p.m., Client #2 made a similar jerk motion with his arms a grunt sound and stomped his feet while interacting with a direct support staff and this surveyor near the front door;

- At 6:29 p.m., Client #2 made a similar jerk motion with his arms and grunt sound after he walked into the dining room (staff were present);

- At 7:01 p.m., Client #2 made the jerk motion and grunt sound twice while seated at the dining room table, after he picked up a chicken leg from his plate; and,

- At 7:08 p.m., while he was still seated at the dining room table, Client #2 made the jerk motion and grunt sound a few times in fast succession after he picked up a slice of bread.

On May 11, 2011, at 1:43 p.m., review of Client #2's BSP, dated November 1, 2009 (updated October 30, 2010) revealed that the jerk motion with grunt sound ("Agitated behavior i.e., tick-like behavior, shaking body, barking...") was identified as Tourette's disorder. Staff were instructed to record every incident of agitation.

On May 11, 2011, at 2:14 p.m., review of Client #2's behavior data sheets revealed that staff who worked the 4 p.m. - 12:30 a.m. shift on the day

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W 252	Continued From page 11 before had documented only one of the five incidents of agitation that were observed by facility staff (they wrote "stomped").	W 252		

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BEHAVIOR RESEARCH ASSOCIATES	5051 LEE STREET NE 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 A licensure survey was conducted from May 10, 2011 through May 11, 2011. A sample of three residents was selected from a population of five men with various cognitive and intellectual disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each resident's active treatment program was monitored by the qualified intellectual disabilities professional (QIDP), for two of the three residents in the sample. (Residents #2 and #3) The findings include: 1. [Cross-refer to I500.2] The QIDP failed to notify guardians of all significant incidents, including a confirmed instance of peer-on-peer abuse and a false allegation of staff-on-resident abuse. 2. [Cross-refer to I379] The QIDP failed to ensure that staff reported all allegations of abuse, to include if/when the allegation was made by a resident with a known history of making false	I 180	1. The QIDP will ensure that all guardians and family members are contacted when an incident occurs within 24 hours of the incident. In the future all guardians and family members will be contacted by the QIDP within 24 hours and this information will be documented on the incident report as well as in the investigation report. 2. The QIDP will insure that when a resident makes an allegation of abuse that it is documented as an incident. In the future the QIDP will ensure that all allegations of abuse are reported and an incident investigation is appropriately completed.	

Health Regulation & Licensing Administration

Anne Gordon — TITLE: President — (X6) DATE: 6/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation & Licensing Administration

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I 180	Continued From page 1	I 180		

allegations.

3. The QIDP failed to ensure that Resident #3's physical therapy (PT) needs were effectively addressed:

a. [Cross-refer to I229.2] The QIDP failed to ensure that all staff were effectively trained (i.e. demonstrated the skills and competencies needed) to assist Resident #3 with negotiating stairs in the facility

It should be noted that on May 11, 2011, at 5:16 p.m., review of Resident #3's Fall Prevention protocol, dated October 1, 2010, revealed that it did not reflect the need for two-person assistance while negotiating the stairs. The QIDP acknowledged that the PT had not updated the protocol to reflect his January 18, 2011 re-evaluation and new recommendations.

b. The QIDP failed to ensure that the facility addressed the recommendation to modify the environment to accommodate Resident #3's physical safety needs, as evidenced by the following:

On May 11, 2011, beginning at 4:27 p.m., review of Resident #3's annual PT assessment, dated January 18, 2011, revealed the recommendation to "Consider installing a ramp in the home over the stairs. The ramp should be foldable and removable to allow entry into the washroom ..." to address his decreased ambulating ability. At the time of the survey, there was no ramp in the facility. At 5:18 p.m., the QIDP acknowledged that almost four months had passed since the PT recommended a portable ramp on January 18, 2011.

3a. The QIDP will ensure that all staff are effectively trained on demonstrated skills for resident #3. The physical therapist has been advised to update the fall prevention protocol and the stair climbing protocol to reflect the need for two person assistance with negotiating the stairs. .In the future the QIDP will ensure that competency training is done quarterly or as needed by the physical therapist to ensure that effective training is done to meet the competency needs of the individuals

3b. The QIDP will ensure that all physical therapy recommendation are met and durable medical equipment received within 30 days as recommended in the adaptive equipment policy. If the equipment is not received the QIDP will follow all guidelines in the future in the durable medical equipment policy. The ramp and portable stairs has been received from [redacted] and being used to meet the need of the individual. The staff will be trained on the durable medical equipment at least quarterly and reviewed monthly for repairs by the house manager.

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I 180	Continued From page 2 4. [Cross-refer to I229.1] The QIDP failed to ensure that staff received training on all facets of behavior intervention, including crisis procedures CPI training. 5. [Cross-refer to Federal Deficiency Report - Citation W252] The QIDP failed to ensure staff documented all incidents of Resident #2's observed targeted behaviors, in accordance with his behavior support plan.	I 180	4. The QIDP will ensure that all staff is trained on all facets of behavior intervention including crisis procedures of CPI training. In the future the QIDP will ensure that /CPI training is done on a annual basis for all staff and that the behavior interventions are reviewed quarterly by the behavior specialist. 5. The QIDP will ensure that all incidents of abuse and any designated target behaviors are recorded within a 24 hour period and reported to the appropriate parties. In the future the QIDP will ensure that all incidents targeting behaviors are reported and staffs are trained on appropriate procedures for incident reporting and when to report an incident at least quarterly.....6-30-11	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that one of the twenty-three consultants (speech pathologist) had a current health certificate. The finding includes: On May 11, 2011, beginning at 12:10 p.m., review of the personnel records revealed the GHPID failed to have evidence of a current health inventory/ certificate for the speech language pathologist. At approximately 12:20 p.m., the QIDP acknowledged that there was no evidence of a health inventory performed by a	I 206	3509.6 BRA is utilizing a new speech pathologist who has both a current health certificate and license...6-17-11	

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I 206	Continued From page 3 physician for either the speech pathologist or her assistant. She further indicated that the consultant had performed an assessment for Resident #4 in November 2010 and that her assistant had been in the GHPID "either in February or March 2011" to assess Resident #3.	I 206		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to show evidence that one of the six nurses had current training to implement emergency measures. The finding includes: On May 11, 2011, beginning at 12:10 p.m., review of personnel files revealed no evidence that one of the six nurses had received current Cardiopulmonary Resuscitation (CPR). At 12:20 p.m., the qualified intellectual disabilities professional confirmed that the LPN was without current CPR certification. She further indicated that the LPN had been hired "recently" and would receive CPR training at the next opportunity it was offered.	I 227	3510.5d A training session will be scheduled for CPR/First Aid for the relevant nursing staff by...7-15-11	

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I 229	Continued From page 4	I 229		
I 229	3510.5(f) STAFF TRAINING	I 229		

Each training program shall include, but not be limited to, the following:

(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;

This Statute is not met as evidenced by:
1. Based on staff interview and record review, the facility failed to ensure that staff received training on all facets of behavior intervention, including crisis procedures, for one of the three residents in the sample. (Resident #2)

The finding includes:

[Cross-refer to I379] On May 10, 2011, beginning at 8:47 a.m., review of incident reports in the facility revealed that on May 29, 2010, staff reported an incident of resident-on-resident abuse. The incident report and its corresponding investigation report, also dated May 29, 2010, described how the client's behaviors escalated and he began banging on a van window (glass). A staff "held the client's hand" to prevent him from injuring himself.

On May 10, 2011, at 10:52 a.m., when asked about the May 29, 2010 incident, the facility's incident management coordinator (IMC) and the qualified intellectual disabilities professional (QIDP) said Client #2 had a Behavior Support Plan (BSP) to address numerous maladaptive behaviors, including physical aggression.

On May 11, 2011, at 1:43 p.m., review of

Staff training records will be reviewed quarterly to insure proactive notification on issues, routine compliance and timely follow up on issues discovered...7-1-11

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Resident #2's BSP, dated November 1, 2009 (updated October 30, 2010) confirmed that the BSP addressed agitation, physical aggression, property destruction and three other target behaviors. The BSP indicated there had been 24 incidents of physical aggression and 53 incidents of property destruction in the preceding year. Further review of the BSP revealed the following: "Only staff trained in <Department on Disability Services> DDS approved crisis prevention techniques may use only the least restrictive crisis prevention techniques to prevent <client's name> from harming himself or others... All staff in the facility should be trained in least restrictive crisis prevention techniques, approved by DDS."

Minutes later, at 1:45 p.m., both the QIDP and IMC indicated that the facility used "CPI, Crisis Prevention Institute" for said training. The QIDP then stated that not all staff were CPI certified. At 2:23 p.m., review of the records presented for CPI training revealed no evidence that eight (8) out of thirteen (13) direct support staff, as well as the house manager, had received training in CPI.

2. Based on observation, interview and record review, the facility failed to ensure that all staff were effectively trained (i.e. demonstrated the skills and competencies needed) to meet the physical support needs of the one resident (out of five) that required physical assistance when negotiating stairs. (Resident #3)

The finding includes:

On May 10, 2011, at approximately 7:05 a.m., Resident #3 informed the house manager that he needed to use the bathroom. He stood up, took hold of his rolling walker and walked independently to the top of a two-step staircase.

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The stairs led from the main living area down to the lower level, where the bathrooms were located. The resident, who was wearing custom molded orthopedic shoes, placed the walker to his right, held it with his right hand and took hold of a hand railing with his left hand. The house manager stood in front of him, below, while the resident lowered himself onto the first step. Resident #3 began vocalizing and hesitated. The house manager held the resident's upper body and offered instructions and encouragement. The resident continued vocalizing and indicated that he was having difficulty. On the second step, the resident's knees bent and the house manager gently lowered him to the floor. After verbal encouragement and a pull to his waist, the house manager assisted Resident #3 back to his feet and they continued towards the bathroom.

At 8:20 a.m., the QIDP stated that Resident #3's health had declined. She acknowledged that the resident "does have difficulty" navigating the steps inside the facility.

Later on May 10, 2011, at 4:59 p.m., Resident #3 was observed climbing the two steps from the lower level to the main living area. It was a slow process and he complained that his "knees hurt." Two staff provided physical assistance and verbal instructions. At 6:52 a.m., however, the resident was observed coming up the steps, with the assistance of only one staff.

Resident #3's physical therapy (PT) records were reviewed on May 11, 2011, beginning at 4:16 p.m. His annual PT assessment, dated January 18, 2011, included the following: "Staff were trained on using the <walker> to negotiate the stairs inside the home using two persons ...mobility continues to decline. There is general

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I 229	Continued From page 7 weakness ... Staff reported increased difficulty negotiating the stairs..." When interviewed again, on May 11, 2011, at 5:14 p.m., the QIDP stated that she had provided staff in-service training on January 18, 2011 at which time she informed staff that the PT had recommended two-person assistance for Resident #3 on the steps while using his walker. She presented a signature sheet of the staff who had attended the January 18, 2011 session. When informed that Resident #3 was observed negotiating the stairs with one-person assistance, the QIDP said she had provided additional staff training, and presented a signature sheet of an in-service training she had conducted on May 4, 2011. Observations on May 10, 2011, however, indicated that the training had not been effective. It should be noted that at 5:17 p.m., review of Resident #3's Fall Prevention protocol, dated October 1, 2010, revealed that the PT had not updated the protocol to reflect his January 18, 2011 recommendations. The QIDP stated that the PT would provide staff in-service training once he updated the resident's Fall Prevention protocol.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within	I 379		

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twenty-four (24) hours or the next work day.

This Statute is not met as evidenced by:
Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for two of the five residents of the GHPID. (Residents #2 and #5)

The findings include:

1. On May 10, 2011, beginning at 8:47 a.m., review of facility incident reports revealed an incident of resident-on-resident abuse, dated May 29, 2010. According to the incident report and staff witness statements, Resident #2 became physically aggressive during a behavioral episode while out in the community. Resident #2's behaviors escalated and he hit one of his peers (Resident #5) in the face. According to two staff witness statements that were attached to the corresponding investigation report, also dated May 29, 2010, Resident #2 made an allegation that another staff had hit him during the incident. Continued review revealed no reference was made to the allegation of physical abuse by staff in either the original incident report or its corresponding investigation report.

2. Pre-survey review of incidents that were reported to the State agency had not indicated any allegation of staff-on-resident abuse. On May 10, 2011, at 10:51 a.m., when asked about the May 29, 2010 incident involving Resident #2,

1. The QIDP will ensure that when a resident makes an allegation of abuse an incident report is immediately generated to reflect that allegation. In the future the QIDP will ensure that all allegations are reported and investigations completed and reviewed in a timely manner.

2. The QIDP will ensure that all incidents of targeted behaviors are documented and reported to the QIDP and incident management coordinator. In the future the QIDP will ensure that all incidents of target behaviors are reported by staff, documented on a behavior data sheet, an incident report form and an investigation completed by the IMU investigator. Training on incident procedures will be done by end of this month

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the facility's incident management coordinator (IMC) said there had been no incident report prepared specifically about the allegation. Both she and the qualified intellectual disabilities professional (QIDP), who was present at that time, stated that making false allegations against staff was one of Resident #2's known, targeted maladaptive behaviors. The IMC and QIDP further indicated that because this was a targeted behavior, Resident #2's allegation would only be documented in the resident's behavior data. However, on May 11, 2011, at 1:12 p.m., review of Resident #2's Behavior Support Plan (BSP) dated November 1, 2009 (updated October 30, 2010), revealed "If <resident's name> makes accusations ... that a staff has physically or verbally abused him ...staff should then inform the <QIDP> and supervisory staff of the details of the accusatory incident ...following this, the staff member should document the details of the incident on the data sheet provided. A serious reportable incident should be recorded on an Incident Report Form and reported to the <QIDP> for immediate follow-up.] Facility staff, however, failed to complete an Incident Report form.

3. During the May 10, 2011 interview with the IMC, at 10:53 a.m., she acknowledged that there was no evidence that the facility's administrator had been notified of Resident #2's allegation of staff-on-resident abuse on May 29, 2010.

Additionally, at the time of the survey, there was no evidence that the aforementioned incident involving Residents #2 and #5 had been reported to DOH/HRLA.

3. The QIDP will ensure that all incident investigations are reviewed by the facility administrators. In the future the QIIDP will ensure that all incidents are properly investigation and the findings from the investigation are reviewed by the facility administrator. The QIDP will also review all investigations before being finalized as a final review to ensure that all parties in accordance including DOH have been notified.....6-30-11

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I 399	Continued From page 10	I 399		
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHPID, for one of the twenty-three consultants, as required by District of Columbia law, in the following discipline or area: (i) Speech and Language Therapy. The findings includes: On May 11, 2011, beginning at 12:10 p.m., review of the personnel records revealed the GHPID failed to have evidence that the speech language pathologist under contract had a current license to practice in the District of Columbia. At approximately 12:20 p.m., the QIDP acknowledged that there was no evidence of a professional license for either the speech pathologist or her assistant. She further	I 399	3520.2(i) BRA is utilizing a new speech pathologist who has both a current health certificate and license...6-17-11	

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I 399	Continued From page 11 indicated that the consultant had performed an assessment for Resident #4 in November 2010 and that her assistant had been in the GHPID "either in February or March 2011" to assess Resident #3.	I 399		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectual disabilities, for one of the three residents in the sample. (Resident #2) The finding includes: Federal Intermediate Care Facilities for Persons with Intellectual Disabilities, Regulation 483.420(c)(6). The facility must notify promptly the resident's parents or guardian of any significant incidents... including but not limited to... accident... abuse..." Chapter 13, § 7-1305.10(e). Mistreatment, neglect or abuse prohibited [Formerly § 6-1970]	I 500		

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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) COMPLETE DATE
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(e) Alleged instances of mistreatment, neglect or abuse of any customer shall be reported immediately to the Director and the Director shall inform the customer's counsel, parent or guardian... of any such instances. There shall be a written report that the allegation has been thoroughly and promptly investigated (with the findings stated therein)...

[Cross-refer to I379] On May 10, 2011, beginning at 8:47 a.m., review of incident reports revealed that on May 29, 2010, Resident #2 became physically aggressive during a behavioral episode and hit one of his peers (Resident #5) in the face. Further review of the incident report revealed no evidence that Resident #5's guardian had been notified of the incident.

On May 10, 2011, at 11:08 a.m., interview with the incident management coordinator (IMC) revealed that the qualified intellectual disabilities professional (QIDP) was responsible for communicating with the residents' families and guardians. When interviewed at 11:35 a.m., the QIDP confirmed that she had not notified Resident #5's guardian of the incident.

It should be noted that review of staff witness statements revealed that on May 29, 2010, Resident #2 alleged that a direct support staff hit him during the behavioral episode. On May 10, 2011, at 11:22 a.m., the QIDP acknowledged that she had not informed Resident #2's guardian of his allegation that a staff had hit him. This surveyor left a message on the guardian's answering machine on May 10, 2011, at 12:58 p.m. The guardian, however, did not return the call before the survey ended.

The QIDP will ensure that every guardian and family member is notified with 24 hours of any allegation of abuse. In the future the QIDP will ensure that all appropriate parties are communicated to when an allegation of abuse occurs. All guardians and family members will be notified by the QIDP of any incident that occurred. The QIDP will also inform the incident management coordinator of all notifications and ensure that this information is documented in the incident investigation. In the future if their are incidents involving tow residents the QIDP will ensure that both incident's guardians or family members are notified and that information documented. The QIDP will ensue that all allegations of abuse are reported to the guardians or family members involved and documented in the investigation report the time that they were notified.....6-17-11