

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000 INITIAL COMMENTS

A recertification survey was conducted from 2/17/2010, through 2/19/2010. The survey was completed utilizing the fundamental survey process.

A random sampling of three clients was selected from a residential population of five males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the client and administrative records, including the incident reports.

W 000

MAR 25 2010

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

The facility must assure that outside services meet the needs of each client.

This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that the day program provided effective intervention strategies to address the needs of one of the five clients residing in the facility. (Client #5)

The findings include:

1. The day program failed to ensure all relevant details were included in the investigation of Client #5's injury as evidenced below:

On 2/18/2010, at 10:40 a.m., review of unusual incident reports revealed a 1/15/2010, incident involving Client #5. According to the report, the client sustained a laceration to the right side of his forehead and a laceration on his left eyebrow.

W 120

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE **03-22-10**

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 HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 120 Continued From page 1
The report further indicated that the client sustained the injury when he tripped over a peer's foot, after leaving the "Time Out area."

The day program investigative report, dated 1/19/2010, documented that as the client fell, he hit his head on the edges of the two chairs that had been placed side by side. The client was immediately evaluated by the day program nurse, who applied first aide until the EMS arrived at 12:15 p.m. to assess the client. At 12:25 p.m., the EMS transported the client to a local hospital emergency room (ER) for further evaluation and treatment. The review of the ER discharge summary dated 1/15/2010 revealed that the client received sutures to his lacerations and he return to his group home later that afternoon.

Interview with the facility's incident management coordinator on 2/19/2010, at 10:55 a.m. revealed that the day program incident manager and the day program nurse had been interviewed regarding the client's injury. The group home, however, had not been able to directly interview the day program staff who was with the client when he fell.

On 2/19/2010, at 2:37 p.m., the Qualified Mental Retardation Professional (QMRP) revealed that the day program had been questioned concerning why the client had been placed in a time out area. The QMRP stated that she was informed that prior to the incident, Client #5 was observed masturbating in the classroom. Reportedly, when the client continued to masturbate, he was escorted from his classroom to another room for his personal privacy. Continued interview with the QMRP revealed that although the masturbation had been mentioned in the discussion, there was

W 120

1. The QMRP supported by the RN will meet with the day program for client #5 to share all of the findings of W120 and discuss appropriate follow up. BRA will insure that the day program has a copy of the updated protocol for managing the masturbation issue. In the future the QMRP will ensure that behavioral issues are addressed appropriately with the day program to include the least restrictive measures ...4-2-10.

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 120	<p>Continued From page 2</p> <p>no mentioning of it in the day program's investigation report.</p> <p>On 2/18/2010, at 2:43 p.m., review of all written statements and the day program's investigative report also revealed no evidence that the Client #5's masturbation had been addressed.</p> <p>2. The day program failed to ensure that Client #5's specific treatment needs were reassessed as evidenced below:</p> <p>Interview with the QMRP on 2/19/2010, at approximately 2:45 p.m., revealed that Client #5 did not have a behavior support plan (BSP) at his day program. The QMRP indicated that although the day program coordinator had mentioned that the client had attempted to masturbate at his day program in the past, there was no evidence that the day program had recommended proactive strategies to the interdisciplinary team to manage it when it occurred.</p> <p>It should be noted that the client did have a BSP dated 10/7/2009, which was being implemented at his group home. It included an objective to "reduce inappropriate self-stimulation in public" (playing with his nipples for self-stimulation, while seated in a communal area)" to 1 incident or less per month for the next consecutive months."</p> <p>Interview with the QMRP on 2/19/2010, at 2:37 p.m., revealed she questioned the day program concerning why the client had been placed in a time out area. The QMRP stated that she was informed that prior to the incident, Client #5 was observed masturbating in the classroom. Reportedly, when the client continued to masturbate, he was escorted from his classroom</p>	W 120	<p>2. BRA will offer to train the day program staff on the new protocol. In the future BRA will ensure that the day program is properly trained on the new protocol...4-2-10</p>	

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010	
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 120	<p>Continued From page 3</p> <p>to another room for his personal privacy.</p> <p>Record review on 2/18/2010, at 2:43 p.m., however, revealed no evidence that strategies to address Client #5's masturbation had been included in his day program written and approved treatment plan.</p> <p>3. The day program failed to provide progress reports to the group home for Client #5 as evidenced below:</p> <p>Interview with the QMRP on 2/19/2010, at 3:30 p.m., revealed that she had visited the Client #5's day program, however, had not received written progress reports since his annual assessment in 4/2009.</p> <p>On 2/19/2010, at 3:35 p.m., the review of Client #5's habilitation record verified that the most current day program report was dated 4/2/2009. The Annual Assessment Report documented the client's problems as:</p> <p>(a) Poor Impulse control as evidenced by improper touching.</p> <p>(b) Impaired socialization skills.</p> <p>To address the identified problems, the following goals were identified:</p> <p>(a) To reduce improper touching by 75% over the next six months.</p> <p>(b) To learn two appropriate touching skills, i.e. handshaking.</p> <p>At the time of the survey, however, there was no</p>	W 120	<p>3. BRA will seek quarterly progress reports during routine visits by the QMRP and will report issues with obtaining the needed reports to the DDS support coordinator for timely follow up...4-2-10</p> <p>In the future the QMRP will monitor implementation of the planned objectives at the day program during routine visits and by reviewing the quarterly summaries obtained.....</p> <p>.....4-2-10</p>	

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 120	Continued From page 4 evidence that the day program had timely submitted a report of the Client #5's progress to the group home to ensure coordination of his treatment needs and services.	W 120		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence that financial records were being maintained for three of three sampled clients. [Clients #1, #2, and #3] The finding includes: The financial records for Clients #1, #2, and #3 were requested for review by the survey team on 2/17/2010 at approximately 4:40 p.m. Interview with the qualified mental retardation professional (QMRP) on the same day and time, revealed the financial records were being maintained at the main office and not on site at the residential facility. As of the close of survey, the financial records were never provided to the survey team for review. The facility failed to provide evidence that a complete accounting of client's personal funds was being maintained for all clients included in the survey sample.	W 140	Copies of Financial records will be readily available in the home. In the future the records will be available at the targeted home on the initial day of the survey4-2-10	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 159	Continued From page 5 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for four of the five clients residing in the facility. (Clients #1, #2, #4 and #5) The findings include: 1. The QMRP failed to coordinate services with the day program to ensure implementation of effective intervention strategies to address the needs of Client #5. [See W120] 2. The QMRP failed to ensure staff was effectively trained to provide Client #2 with proper assistance during ambulation. [See W189] 3. The QMRP failed to ensure the consistent implementation of the ambulation programs for Clients #2 and #4. [See W249] 4. The QMRP failed to ensure the implementation of an effective system of documenting Client # 4's ambulation program as recommended. [See W252] 5. The QMRP failed to coordinate services to ensure that Client #1's shower chair was provided with straps as recommended. [See W436]	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with	W 189			

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 189	<p>Continued From page 6</p> <p>initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to ensure clients received the proper assistance during ambulation for one of three sampled clients. [Client #2]</p> <p>The finding includes:</p> <p>Observation on the evening of 2/17/2010, between the hours of 4:55 p.m. and 6:10 p.m., revealed Client #2 and the Shift Supervisor were observed playing with a ball in the living room. Client #2 was observed to be unsteady while maneuvering around the living room. He was able to stabilize himself as he walked around, but a few times he had to use his immediate surroundings to regain his balance. On two occasions he stumbled onto this surveyor and also stumbled onto his house mate two additional times while playing with the Shift Supervisor. His house mate was sitting in a lounge chair on the other side of the living room from this surveyor.</p> <p>At no time was Client #2 provided any assistance as he navigated himself around the living room, kicked the ball around, or picked it up to throw it across the room.</p> <p>Client #2 was again observed navigating the environment at his day program without any staff assistance on 2/18/2010, at approximately 10:30 a.m.</p>	W 189			
			All issues cited under W159 have been addressed as evidenced by the responses for W120, W189, W249, W252 and W436.		

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 189	Continued From page 7 Record review on 2/19/2010, at approximately 3:24 p.m., revealed Client #2's Health Risk Management Care Plan (HRMCP) dated 11/4/2009 identified, "Risk Management Procedures: Direct care staff is to assist with all ambulation and transfers...". Additional record review and interview with the facility's qualified mental retardation professional (QMRP) on 2/19/2010, at approximately 3:35 p.m., verified there was no evidence that staff received effective training to provide Client #2 assistance when ambulating since 11/4/2009, as dated on the HRMCP.	W 189	Although staff had been trained on the ambulation support needs of Client #2, they will be re-trained and will be addressed by the Physical Therapist concerning ambulation procedures by...3-28-10. Additionally, in the future the QMRP will observe active treatment as implemented by the staff at minimum once weekly for every shift to insure that the assistance provided Client #2 during ambulation is consistent with his needs. The Health Risk Management Care Plan will also be revised by...3-38-10.
W 217	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment of the nutritional needs of one of the three clients in the sample. (Client #1) The finding includes The facility failed to ensure a timely and comprehensive reassessment of Client #1's nutritional status, after his extended hospitalization as evidenced below: On 2/17/2010, at 6:10 p.m., Client #1 was observed seated in his wheelchair at the dining table. He was observed to require hand over hand assistance to prevent spillage while eating his ground diet. During the observation of the	W 217	

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 217	<p>Continued From page 8</p> <p>medication administration at approximately 6:48 p.m., the licensed practical nurse (LPN) was observed to apply Bactroban Ointment to a small healing decubitus on his buttocks.</p> <p>Interview with staff on 2/18/2010, at 5:40 p.m., revealed that Client #1's appetite had been good since his 1/15/2010, readmission to the group home from the hospital. Interview with the primary LPN on 2/19/2010, at approximately 5:00 p.m., however, revealed that the client's overall nutritional and medical status had declined during his hospitalization. (11/28/09 to 1/15/2010) The nurse indicated that the client had not received the necessary services to maintain his ambulation during his hospitalization. According to the nurse, the staff had first noticed a red area on the client's buttock on 1/20/2010, five days after his readmission. Further interview with the nurse revealed as soon as the area on the client's buttocks was discovered on 1/20/2010, the primary care physician (PCP) and physical therapist (PT) were notified and treatment orders were received. Staff were instructed to turn the client from left to right every two hours in his bed and to not allow his time in the wheelchair to exceed one hour, except when on appointments. The nurse stated that the client was reassessed by the PCP on 1/21/2010, and by the PT on 1/22/2010.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 2/19/2010, at 4:30 p.m. concerning Client #1's nutritional follow-up after his readmission to the group home, revealed that the nutritionist had assessed the client on 2/16/2010, four weeks after his return from the hospital.</p>	W 217	<p>BRA will seek to set up and attend exist conferences for any individual who has a hospital stay and based on the information obtained, will set up the needed follow up (in-home) examinations and treatment by the PCP and other appropriate team members within the first 48 hours for critical concerns and in a timely manner for all concerns...4-2-10.</p> <p>The RN will examine anyone discharged from a hospital stay within 24 hours of their discharge and will report the findings to the PCP...4-2-10.</p> <p>The HMCP will be modified for the person discharged and based on the discharge meeting feedback as well as the discharge summary within 24 hours, given the approval of the PCP for all recommended follow up...4-2-10.</p> <p>Client #1 lost significant weight during the hospital stay but has not lost further since that time and appears to be adjusting to his diet and fluid regimen at home. His weight will be monitored weekly and his food/liquid intake will be recorded daily beginning...3-26-10.</p> <p>The Decubitus is being routinely treated and is healing. The HMCP will be modified to reflect the treatment of the Decubitus and the weight concerns...3-26-10.</p> <p>The survey feedback will be shared with the nutritionist who will be asked to provide feedback specifically on the caloric and protein needs of Client #1. This feedback will be obtained by.....4-2-10.</p> <p>The HMCP and physician's orders will be adjusted to reflect the nutritionist's recommendations...4-3-10.</p>		

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 217	Continued From page 9 Record review on 2/19/2010, at 4:47 p.m. revealed a second quarterly nutrition review dated 12/28/2009, that indicated the client would be assessed by the nutritionist after he returned to the group home. The next nutrition consultation report, dated 2/17/2010, documented that the nutritionist was not aware of the decubitus until 2/15/2010. Although the nutritional assessment provided dietary recommendations, it failed to identify the client's specific caloric and protein needs after his readmission from the hospital. At the time of the survey, there was no evidence the facility had ensured a timely and comprehensive reassessment of Client #1's nutritional needs.	W 217			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to consistently implement a client's ambulation program for one of five clients residing in the facility. [Client #4] The finding includes: Observation on the evening of 2/17/2010, at approximately 4:30 p.m., revealed Client #4 was	W 249			

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 249	<p>Continued From page 10</p> <p>brought to the dinner table for snack by his attending staff. He ate his snack and remained at the dinner table until approximately 5:15 p.m., when the evening medication nurse arrived. At that time, his attending staff assisted him to a room down the hall from the dining room to wait for his medications. He sat in that room for the evening medications until dinner.</p> <p>At approximately 6:00 p.m., Client #4 was assisted to the dinner table in preparation for dinner. At approximately 6:25 p.m., he was about half way done eating his meal and was offered a beverage by staff. At approximately 6:40 p.m., Client #4 was observed sitting at the dinner table with most of his meal completed. During this time he began to fall asleep as he sat staring at his plate of food. Staff redirected him to wake up and to finish his meal.</p> <p>Record review on 2/19/2010, at approximately 5:45 p.m., revealed Client #4's ambulation program dated 5/3/2009, required that he "will ambulate two trips around the interior of his home using his rolling walker with contact guard assistance every 2 hours that he is awake at 100% accuracy". Review of the data sheet for this intervention on the same day and time revealed, the facility's staff documented that he completed one trial of the ambulation program at 6:00 p.m. on the evening of 2/17/2010.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) and the registered nurse (RN) on 2/19/2010, at approximately 5:55 p.m., verified there was no evidence the staff was consistently and effectively implementing the ambulation program as written.</p>	W 249	<p>The Physical Therapy Program has been revised. Staff will be re-trained by the Physical Therapist on providing proper support to Client #4 during ambulation and on collecting the data accurately for the program...4-2-10. The QMRP will monitor data collection at minimum 3 times weekly and will observe staff running the program at least twice weekly...4-2-10. Staff will receive on the spot training if they fail to perform properly or disciplinary action if that is most appropriate...4-2-10.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 249	Continued From page 11 The facility failed to ensure the accurate documentation and recording of data for Client #4's ambulation program as recommended.	W 249		
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, staff interview and record review the facility failed to ensure the implementation of an effective system of documenting a client's ambulation program as recommended for one of five clients residing in the facility. [Client #4] The finding includes: [Cross Reference W249] Observation on the evening of 2/17/2010, at 6:00 p.m. revealed, Client #4 was sitting at the dinner table preparing to eat his dinner. At approximately 6:25 p.m. Client #4 was about half way done eating his meal and was offered a beverage by staff. At approximately 6:40 p.m. , Client #4 was observed sitting at the dinner table with most of his meal completed. During this time he began to fall asleep as he sat staring at his plate of food. Staff redirected him to wake up and to finish his meal. Record review on 2/19/2010, at approximately 5:45 p.m., revealed Client #4's ambulation program required that he "will ambulate two trips	W 252	See: responses for W249.	

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 252	Continued From page 12 around the interior of his home using his rolling walker with contact guard assistance every 2 hours that he is awake at 100% accuracy". Review of the data sheet for this intervention on the same day and time revealed, the facility's staff documented that he completed one trial of the ambulation program at 6:00 p.m. on the evening of 2/17/2010. In addition, there was no data entered between the hours of 8 a.m. and 2 p.m. for 2/17/2010, as well. Interview with the facility's qualified mental retardation professional (QMRP) and the registered nurse (RN) on 2/19/2010, at approximately 5:55 p.m., verified that the data collected on 2/17/2010 was inaccurate and that there was no evidence the staff had consistently implemented the ambulation program as written. The facility failed to ensure the accurate documentation and recording of data for Client #4's ambulation program as recommended.	W 252			
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to update a client's health management care plan to address the treatment and care of a decubitus ulcer for one of three sampled clients. [Client #4] The finding includes:	W 259			

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 259	Continued From page 13 [Cross Reference W249] Record review on 2/18/2010, at approximately 10:30 a.m., revealed an Unusual Incident Report was drafted on 1/20/2010, to address the finding of a skin breakdown between Client #4's buttocks. Review of Client #4's medical record on 2/19/2010, at approximately 5:30 p.m., revealed the primary care physician assessed the skin break down as being a "shallow early decubitus in the buttock fold" on 1/21/2010. The assessment further prescribed a course of treatment that included the application of "Bactroban and gauze three times a day (TID) until healed". This course of treatment was mirrored in the 1/21/2010 nursing notes. Review of the Health Risk Management Care Plan (HRMCP) dated 11/26/2009, revealed the treatment plan for the care and monitoring of the decubitus in the folds of Client #4's buttocks was not listed. Interview with the facility's qualified mental retardation professional (QMRP) and the registered nurse (RN) on 2/19/2009, at approximately 5:40 p.m. revealed the 11/2009 care plan was not updated to reflect the treatment of the decubitus. Both the QMRP and the RN indicated it was an oversight and that the omission would be corrected immediately.	W 259	The HMCP will be updated for Client #4 by...3-26-10. The new RN will receive training on HMCP updates from the Health Resources Partnership support RN by...4-15-10. The QMRP and Program Manager will provide guidance by...3-30-10.	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility failed to update the HRMCP to accurately reflect Client #4 current health status. The facility must provide or obtain preventive and general medical care.	W 322		

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 322	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure timely preventive health services for one of three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>[Cross refer to W217] On 2/17/2010, at approximately 6:48 p.m., observation of Client #1 revealed that the licensed practical nurse (LPN) applied Bactroban Ointment to a small healing decubitus on his sacral area.</p> <p>Interview with the facility staff on 2/17/2010, at approximately 5:30 p.m., revealed since Client #1's re-admission to the group home, his ability to ambulate safely had declined and required maximum assistance with his activities of daily living (ADL). Interview with the LPN on 2/17/2010, at approximately 6:40 p.m. revealed the client's health status had declined during his extended hospitalization from 11/28/2009 to 1/15/2010. Further interview with the nurse indicated that the client had not received services to maintain his ambulation during his hospitalization, due to reported uncooperative behavior when the physical therapist (PT) attempted to evaluate him at his bedside.</p> <p>Continued interview with the nurse on February 19, 2010, at 4:30 p.m., revealed staff first noticed a red area on the client's sacrum on 1/20/2010, five days after his readmission to the group home. The nurse indicated that the primary care physician (PCP) and physical therapist (PT) were notified as soon as the area was discovered on</p>	W 322	<p>BRA will seek to set up and attend exist conferences for any individual who has a hospital stay and based on the information obtained, will set up the needed follow up (in-home) examinations and treatment by the PCP and other appropriate team members within the first 48 hours for critical concerns and in a timely manner for all concerns... 4-2-10.</p> <p>The RN will examine anyone discharged from a hospital stay within 24 hours of their discharge and will report the findings to the PCP... 4-2-10.</p> <p>The HMCP will be modified for the person discharged and based on the discharge meeting feedback as well as the discharge summary within 24 hours, given the approval of the PCP for all recommended follow up... 4-2-10.</p>	

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 322	<p>Continued From page 15</p> <p>1/20/2010. Staff was instructed to turn the client from left to right every two hours in his bed and to not leave him in his wheelchair for more than one hour, except when on appointments.</p> <p>Record review on 2/18/2010, at 10:30 a.m., confirmed an unusual incident dated 1/20/2010 (6:00 p.m.), had revealed staff "noticed what appeared to be a small reddish open area between his buttocks...." Continued record review revealed the client had been in an acute care hospital from 11/28/2009 to 12/10/2009. On 12/10/2009, he was transferred to a sub acute hospital for extended antibiotic Methicillin-Resistant Staphylococcus Aureus (MRSA) therapy, where he remained until 1/15/2010. Nursing progress notes revealed the Client #1's ambulation had declined during his extended hospitalization.</p> <p>On 2/19/2010, at 4:55 p.m., the readmission physician's orders dated 1/15/2010 were reviewed, which were signed by the PCP on 1/21/2010. The orders instructed the nurse to "Resume the following orders and medications on return to group home." Upon notification by the nurse of the aforementioned reddened area on Client #1's sacrum, the PCP provided a verbal order to treat the client. The order dated 1/21/2010 stated, "Bactroban Ointment to anal area TID until healed, cover with gauze." The PCP consultation referral dated 1/21/2010 revealed, the purpose of the visit was to "Evaluate... Discharge and Return to Day Program." The PCP diagnosis included ..."Buttock - early, shallow decubitus in buttock fold...." Recommendation: " Bactroban to buttock TID, cover with gauze until healed. Return to day program." Further record review revealed a PT</p>	W 322			

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE	
W 322	<p>Continued From page 16</p> <p>reassessment was completed on 1/22/2010 and revealed a recommendation to discontinue the ambulation and noted that the client had an ulcer on his coccyx. In-service training was also provided that day on bed mobility, wheelchair transfers and safety, falls and repositioning.</p> <p>Client #1's nursing progress notes were reviewed on 2/19/10, at 5:07 p.m. to determine the client's progress after his readmission to the group home, and revealed the following information:</p> <p>a. 1/15/2010 - (Nursing readmission progress note): The section on skin condition noted: "Skin: Left upper chest wall incision well healed. No s/s infection. Left upper arm former PICC line site benign"...."The PCP was made of aware of [client's] discharge back to the group home. Follow-up with PCP next week.</p> <p>b. 1/17/2010 - the nurse documented, "skins intact...continue to monitor."</p> <p>The review of nursing progress notes on 2/19/2010 at 4:55 p.m. also revealed the following information concerning an alteration in Client #1's skin integrity:</p> <p>a. 1/20/2010 at 3:00 p.m., (LPN progress note) - "Staff reported sacral skin issue, non-bleeding, with discoloration. [Client] will see PCP on 1/21/2010 (LPN) (3:30 p.m.) - Sacral area cleaned and treated with A & D ointment. Staff aware to report s/s of distress and to provide the proper skin care."</p> <p>b. 1/20/2010 at 8:15 p.m. (nursing progress note) - "Notified of gluteal breakdown this evening. Staff instructed to turn and reposition every 2 hours.</p>	W 322			

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 322	Continued From page 17 Area cleaned with soap and water, and then patted dry. A & D ointment skin protectant applied. To see PCP in a.m." Staff was instructed to turn the client from left to right every two hours in his bed and to not leave him in his wheelchair for more than one hour, except when on appointments. c. 1/21/2010, 5:40 p.m. (nursing progress note) - "Sacral wound observed with 100% yellowish tissue. Tissue presents as slough @ present. Wound unstageable @ present...wound edges even; periphery darkened. Wound without exudate or tunneling. Bactroban per orders and cover with gauze. Direct care staff instructed to turn client every two hours. When in bed, to be turned every two hour to left and right trochanter. Completely relieve of all pressure when in bed." d. 1/23/2010 (nursing progress note) - "Wound care treatment to sacral ulcer stage II as ordered...yellowish tissue was noted on wound....no exudate or odor were noted. Treated as ordered." At the time of the survey, there was no evidence timely preventive measures had been established for Client #1 at the time of his readmission to his group home, to minimize the risk of alteration in skin integrity.	W 322		
W 436	483.470(g)(2) SPACE AND EQUIPMENT 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.	W 436		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436 Continued From page 18

W 436

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure a client received and maintained an orthotic foot device for one of three sampled clients. [Client #2]

The finding includes:

1. Observation on the evening of 2/17/2010, between the hours of 4:15 p.m. and 7:00 p.m., revealed Client #2 was observed wearing a pair of high-top black sneaker boots at home while he played ball with the Shift Supervisor. Client #2 was again observed wearing the same black sneaker boots at his day program on 2/18/2010 at approximately 10:30 a.m. and there was no observable evidence that he was wearing an ankle/foot orthosis (AFO) device.

Record review on 2/19/2010, at 3:17 p.m. revealed Client #2's 7/24/2009, Physical Therapy (PT) assessment identified he was provided an AFO for his left ankle and the he wore them in support with a pair of high top sneakers.

Additional review of Client #2's medical record on 2/19/2010, at approximately 3:25 p.m., revealed his Health Risk Management Care Plan (HRMCP) dated 11/4/2009 identified the following concerns:

1. "Unsteady gait, at risk for falls ... History of left ankle fracture. Received left ankle AFO (ankle, foot orthosis) refuse to wear, need repair of ankle strap and new shoes. AFO repaired 3/09."

1. Client #2 is scheduled to be re-fitted for the AFO on.....3-29-10.

Upon receiving a proper fitting AFO, Client #2 will wear the new AFO daily with low cut sneakers...3-30-10. The RN and QMRP will monitor compliance routinely.....4-2-10

The shower chair has been ordered and is expected by.....3-31-10.

In the future, the RN supported by the QMRP will insure that all recommended adaptive equipment is ordered and obtained in a timely manner. This issue will be addressed in a home and person-specific manner during weekly management team meetings...4-2-10.

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436	<p>Continued From page 19</p> <p>2. "Splint worn for ½ hour increments until worn all day ..."</p> <p>3. "Risk Management Procedures: Assure that [Client #2] has low top sneakers at all times with the use of the AFO daily."</p> <p>Record review failed to provide any evidence this client had worn his AFO since the date of his 7/24/2009 Physical Therapy assessment.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 2/19/2010, at approximately 3:30 p.m., revealed Client #2 was not wearing his AFO because he refused to wear it and because he was refitted for a new one on 1/22/2010. The QMRP further explained that he was not wearing a pair of "low-top sneakers" because they were only to be worn with his AFO.</p> <p>Additional interview, with the assistance of the QMRP, on the same day and time verified there was no evidence on file to substantiate Client #2 wore his AFO since 7/24/2009.</p> <p>The facility failed to ensure the implementation of an effective system to ensure Client #2 wore his AFO daily as recommended in his 7/24/2009, Physical Therapy assessment.</p> <p>2. The facility failed to ensure Client #1 new shower chair was equipped with straps as prescribed, as evidenced below:</p> <p>Observation of the shower on 2/19/2010, at approximately 7:00 p.m. revealed a shower chair with a low back and a left arm support.</p> <p>Interview with the QMRP on 2/19/2010, at</p>	W 436		
-------	---	-------	--	--

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W 436	<p>Continued From page 20</p> <p>approximately 7:02 p.m. revealed that the observed shower chair had been recommended for Client #1 by the PT in 12/2009. Further interview with the QMRP revealed that this new shower chair was delivered to the facility without the recommended straps. According to staff and QMRP interview, the client was provided 2 person assists during showers. The QMRP indicated that the physical therapist (PT) returned to the facility on 1/22/2010, to reassess the client, and to instruct staff on the client's current PT needs.</p> <p>On 2/19/2010, at 7:10 p.m., the review of a PT note dated 12/17/2009, revealed staff reported that Client #2 used the shower/tub combo and a tub bench when receiving a shower. According to the assessment, staff had reported that the client may exhibit maladaptive behavior before and/or during showers, which presented a safety concern. The PT recommended that a tub bench with a seat belt and back support be purchased for the client and to continue 2 person assists during shower. Review of the 1/22/2010 PT reassessment of the client, revealed the 12/17/2009 recommendations were continued.</p> <p>At the time of the survey, however, there was no evidence the client's new shower bench had been modified with straps as prescribed.</p>	W 436	
W9999	<p>FINAL OBSERVATIONS</p> <p>The following observation was made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent potential non-compliant practice:</p> <p>[Cross Reference W436]</p>	W9999	

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W9999	<p>Continued From page 21</p> <p>Observation on the evening of 2/17/2010, between the hours of 4:15 p.m., 7:00 p.m., and again on 2/18/2010, at approximately 10:30 a.m., revealed Client #2 was wearing a pair of high top black sneaker boots as part of his attire.</p> <p>Record review on 2/19/2010, at 3:17 p.m., revealed Client #2's 7/24/2009, Physical Therapy assessment identified he was provided an AFO for his left ankle and that he wore them in support with a pair of high top sneakers. Client #2 was not observed wearing an AFO during the survey.</p> <p>Additional review of Client #2's medical record on 2/19/2010, at approximately 3:25 p.m., revealed his Health Risk Management Care Plan (HRMCP) dated 11/4/2009 identified the following:</p> <ol style="list-style-type: none"> "Splint worn for ½ hour increments until worn all day ..." "Risk Management Procedures: Assure that [Client #2] has low top sneakers at all times with the use of the AFO daily." <p>Record review failed to provide any evidence this client wore his AFO in "1/2 hour increments" as recommended. There was also no evidence that he had worn his AFO since the date of his 7/24/2009 Physical Therapy assessment.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 2/19/2010, at approximately 3:30 p.m. revealed Client #2 was not wearing his AFO because he refused to wear it and because he was refitted for a new one on 1/22/2010. The QMRP further explained that he was not wearing a pair of "low-top sneakers"</p>	W9999	<ol style="list-style-type: none"> Client #2 is scheduled to be re-fitted for the AFO on.....3-29-10. Upon receiving a proper fitting AFO, Client #2 will wear the new AFO daily with low cut sneakers...3-30-10. The RN and QMRP will monitor compliance routinely.....4-2-10 The shower chair has been ordered and is expected by.....3-31-10. In the future, the RN supported by the QMRP will insure that all recommended adaptive equipment is ordered and obtained in a timely manner. This issue will be addressed in a home and person-specific manner during weekly management team meetings...4-2-10.

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

PRINTED: 03/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G134	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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) COMPLETION DATE
W9999	<p>Continued From page 22</p> <p>because they were only to be worn with his AFO. There was no documented evidence that a course of treatment/schedule was drafted to address his "refusal" since 7/2009 to wear the AFO.</p> <p>Further interview with the QMRP on the same day and time verified there was no course of treatment in place to schedule when Client #2 was to wear his AFO.</p>	W9999		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 re-licensure survey was conducted from 2/17/2010 through 2/19/2010. A random sampling of three residents was selected from a residential population of five males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the resident and administrative records, including the incident reports.

I 000

I 183: 3508.4 ADMINISTRATIVE SUPPORT

Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.

This Statute is not met as evidenced by:
Based on staff interview and record review, the GHMRP's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a resident's habilitation and planning for two of five residents residing in the GHMRP. [Residents #2 and #4]

The finding includes:

1. The QMRP failed to ensure staff was effectively trained to ensure residents received the proper assistance during ambulation. [See Federal deficiency report citation W189]
2. The QMRP failed to ensure the consistent implementation of residents' ambulation programs. [See Federal deficiency report citation W249]
3. The QMRP failed to ensure the implementation of an effective system of documenting a resident's ambulation program as

I 183

3508.4

Although staff had been trained on the ambulation support needs of Client #2, they will be re-trained and will be addressed by the Physical Therapist concerning ambulation procedures by...3-28-10.
Additionally, in the future the QMRP will observe active treatment as implemented by the staff at minimum once weekly for every shift to insure that the assistance provided Client #2 during ambulation is consistent with his needs. The Health Risk Management Care Plan will also be revised by...3-38-10.

The Physical Therapy Program has been revised. Staff will be re-trained by the Physical Therapist on providing proper support to Client #4 during ambulation and on collecting the data accurately for the program...4-2-10.
The QMRP will monitor data collection at minimum 3 times weekly and will observe staff running the program at least twice weekly...4-2-10.
Staff will receive on the spot training if they fail to perform properly or disciplinary action if that is most appropriate...4-2-10.

Health Regulation Administration

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

Shonda Robinson, Acting Program Director (X6) DATE 3/8/10

STATE FORM

6899

Q89B11

If continuation sheet 1 of 13

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010	
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 183	Continued From page 1 recommended. [See Federal deficiency report citation W252]	I 183		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence that a financial record was being maintained for three of three sampled residents. [Residents #1, #2, and #3] The finding includes: The financial records for Residents #1, #2, and #3 were requested for review by the survey team on 2/17/2010, at approximately 4:40 p.m. Interview with the qualified mental retardation professional (QMRP) on the same day and time revealed the financial records were being maintained at the main office and not on site at the residential facility. As of the close of survey, the financial records were never provided to the survey team for review. The facility failed to provide evidence that a complete accounting of resident's personal funds was being maintained for all residents included in the survey sample.	I 189	3508.7 Copies of Financial records will be readily available in the home. In the future the records will be available at the targeted home on the initial day of the survey 4-2-10	
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control.	I 202		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 202	Continued From page 2 This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all staff was provided a written job description as required by this section. [Staffs #4, #5, #7, #8, #9, #12, #13, #14, #16 and #18] The finding includes: Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 2/19/2010, at approximately 11:45 a.m., revealed ten out of eighteen staff was without a written job description in their personnel files.	I 202	3509.2 The job descriptions for all support staff have been signed and completed. All were in place. BRA will insure that in future surveys, documents are presented for review in an orderly manner and in a timely manner...4-2-10
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 record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure three of eighteen staff secured an annual health inventory as required by this section. [Staff #4, #7, and #12] The finding includes: Record review and interview with the GHMRP 's qualified mental retardation professional (QMRP)	I 206	3509.6 The staff members (3) without current health certificates have been notified and will have new health certificates submitted by...4-10-10 BRA tracks compliance quarterly and notifies staff proactively to update required personnel file information...4-2-10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 206	Continued From page 3 on 2/19/2010, at approximately 2:00 p.m., revealed three out of eighteen staff did not have a current health inventory on file.	I 206		
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, staff interview and record review, the GHMRP failed to ensure staff was effectively trained to ensure residents received the proper assistance during ambulation for one of three sampled residents. [Resident #2] The finding includes: [See Federal deficiency report citation W189] Observation on the evening of 2/17/2010, between the hours of 4:55 p.m. and 6:10 p.m. revealed Resident #2 and the Shift Supervisor was observed playing with a ball in the living room. At no time was Resident #2 provided any assistance as he walked around the living room, kicked the ball around, or picked it up to throw it across the room. Resident #2 was again observed navigating the environment at his day program without any staff assistance on 2/18/2010, at approximately 10:30 a.m. Record review on 2/19/2010 at approximately 3:24 p.m. , revealed Resident #2's Health Risk Management Care Plan (HRMCP) dated 11/4/2009 identified, "Risk Management Procedures: Direct care staff is to assist with all ambulation and transfers..."	I 222	3510.3 Although staff had been trained on the ambulation support needs of Client #2, they will be re-trained and will be addressed by the Physical Therapist concerning ambulation procedures by...3-28-10. Additionally, in the future the QMRP will observe active treatment as implemented by the staff at minimum once weekly for every shift to insure that the assistance provided Client #2 during ambulation is consistent with his needs. The Health Risk Management Care Plan will also be revised by...3-38-10.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 229	Continued From page 5 Therapy assessment identified he was provided an AFO for his left ankle and that he wore them in support with a pair of high top sneakers. Additional review of Resident #2's medical record on 2/19/2010 at approximately 3:25 p.m. revealed his Health Risk Management Care Plan (HRMCP) dated 11/4/2009 identified the following: 1. "Splint worn for ½ hour increments until worn all day ..." 2. "Risk Management Procedures: Assure that JJ has low top sneakers at all times with the use of the AFO daily." Record review failed to provide any evidence this resident wore his AFO in "1/2 hour increments" as recommended. There was also no evidence that he had worn his AFO since the date of his 7/24/2009, Physical Therapy assessment. Furthermore, there was no documented evidence that a course of treatment and/or schedule was drafted to outline the wearing of the AFO. Additional interview and record review, with the assistance of the QMRP, on the same day and time verified there was no evidence on file to substantiate a plan of care was drafted to provide a schedule for wearing the AFO.	I 229		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by:	I 261		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 261	Continued From page 6 Based on staff interview and record review, the GHMRP failed to provide the financial records for all persons residing in the facility. [Residents #1, #2, #3, #4 and #5] The finding includes: The financial records for Residents #1, #2, #3, #4 and #5 were requested for review by the survey team on 2/17/2010, at approximately 4:40 p.m. Interview with the qualified mental retardation professional (QMRP) on the same day and time revealed the financial records were being maintained at the main office and not on site at the residential facility. As of the close of survey, the financial records were never provided to the survey team for review. The facility failed to provide the survey team with the Resident's financial records during the re-licensure inspection as required by this section.	I 261	3512.2 Copies of Financial records will be readily available in the home. In the future the records will be available at the targeted home on the initial day of the survey4-2-10	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that professional services were provided in accordance with the needs of one of three residents in the sample. (Resident #1)	I 401		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010	
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 401	<p>Continued From page 7</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure a comprehensive assessment of the nutritional needs of Resident #1.</p> <p>On 2/17/2010, at 6:10 p.m., Resident #1 was observed seated in his wheelchair at the dining table. He was observed to require hand over hand assistance to prevent spillage while eating his ground diet. During the observation of the medication administration at approximately 6:48 p.m., the licensed practical nurse (LPN) was observed to apply Bactroban Ointment to a small healing decubitus on his buttocks.</p> <p>Interview with staff on 2/18/2010, at 5:40 p.m., revealed that Resident #1's appetite had been good since his 1/15/2010, readmission to the group home from the hospital. Interview with the primary LPN on 2/19/2010, at approximately 5:00 p.m., however, revealed that the resident's overall nutritional and medical status had declined during his hospitalization. (11/28/09 to 1/15/2010) The nurse indicated that the resident had not received the necessary services to maintain his ambulation during his hospitalization. According to the nurse, the staff had first noticed a red area on the resident's buttock on 1/20/2010, five days after his readmission. Further interview with the nurse revealed as soon as the area on the resident's buttocks was discovered on 1/20/2010, the primary care physician (PCP) and physical therapist (PT) were notified and treatment orders were received. Staff were instructed to turn the resident from left to right every two hours in his bed and to not allow his time in the wheelchair to exceed one hour, except when on appointments. The nurse stated that the resident was reassessed by the PCP on 1/21/2010, and by the</p>	I 401	<p>3520.3</p> <p>BRA will seek to set up and attend exist conferences for any individual who has a hospital stay and based on the information obtained, will set up the needed follow up (in-home) examinations and treatment by the PCP and other appropriate team members within the first 48 hours for critical concerns and in a timely manner for all concerns... 4-2-10.</p> <p>The RN will examine anyone discharged from a hospital stay within 24 hours of their discharge and will report the findings to the PCP... 4-2-10.</p> <p>The HMCP will be modified for the person discharged and based on the discharge meeting feedback as well as the discharge summary within 24 hours, given the approval of the PCP for all recommended follow up... 4-2-10.</p>	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 401	Continued From page 8 PT on 1/22/2010. Interview with the Qualified Mental Retardation Professional (QMRP) on 2/19/2010, at 4:30 p.m. concerning Resident #1's nutritional follow-up after his readmission to the group home, revealed that the nutritionist had assessed the resident on 2/16/2010, four weeks after his return from the hospital. Record review on 2/19/2010, at 4:47 p.m. revealed a second quarterly nutrition review dated 12/28/2009, that indicated the resident would be assessed by the nutritionist after he returned to the group home. The next nutrition consultation report, dated 2/17/2010, documented that the nutritionist was not aware of the decubitus until 2/15/2010. Although the nutritional assessment provided dietary recommendations, it failed to identify the resident's specific caloric and protein needs after his readmission from the hospital. At the time of the survey, there was no evidence the GHMRP had ensured a timely and comprehensive reassessment of Resident #1's nutritional needs. 2. The facility failed to ensure timely preventive health services for Resident #1. On 2/17/2010, at approximately 6:48 p.m., observation of Resident #1 revealed that the licensed practical nurse (LPN) applied Bactroban Ointment to a small healing decubitus on his sacral area. Interview with the GHMRP staff on 2/17/2010, at approximately 5:30 p.m., revealed since Resident	I 401		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 401	Continued From page 9 #1's re-admission to the group home, his ability to ambulate safety had declined and required maximum assistance with his activities of daily living (ADL). Interview with the LPN on 2/17/2010, at approximately 6:40 p.m. revealed the resident's health status had declined during his extended hospitalization from 11/28/2009 to 1/15/2010. Further interview with the nurse indicated that the resident had not received services to maintain his ambulation during his hospitalization, due to reported uncooperative behavior when the physical therapist (PT) attempted to evaluate him at his bedside. Continued interview with the nurse on February 19, 2010, at 4:30 p.m., revealed staff first noticed a red area on the resident's sacrum on 1/20/2010, five days after his readmission to the group home. The nurse indicated that the primary care physician (PCP) and physical therapist (PT) were notified as soon as the area was discovered on 1/20/2010. Staff was instructed to turn the resident from left to right every two hours in his bed and to not leave him in his wheelchair for more than one hour, except when on appointments. Record review on 2/18/2010, at 10:30 a.m., confirmed an unusual incident dated 1/20/2010 (6:00 p.m.), had revealed staff "noticed what appeared to be a small reddish open area between his buttocks...." Continued record review revealed the resident had been in an acute care hospital from 11/28/2009 to 12/10/2009. On 12/10/2009, he was transferred to a sub acute hospital for extended antibiotic Methicillin-Resistant Staphylococcus Aureus (MRSA) therapy, where he remained until 1/15/2010. Nursing progress notes revealed the Resident #1's ambulation had declined during his	I 401			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 401	Continued From page 10 extended hospitalization. On 2/19/2010, at 4:55 p.m., the readmission physician's orders dated 1/15/2010 were reviewed, which were signed by the PCP on 1/21/2010. The orders instructed the nurse to "Resume the following orders and medications on return to group home." Upon notification by the nurse of the aforementioned reddened area on Resident #1's sacrum, the PCP provided a verbal order to treat the resident. The order dated 1/21/2010 stated, "Bactroban Ointment to anal area TID until healed, cover with gauze." The PCP consultation referral dated 1/21/2010 revealed, the purpose of the visit was to "Evaluate... Discharge and Return to Day Program." The PCP diagnosis included "...Buttock - early, shallow decubitus in buttock fold...." Recommendation: " Bactroban to buttock TID, cover with gauze until healed. Return to day program." Further record review revealed a PT reassessment was completed on 1/22/2010 and revealed a recommendation to discontinue the ambulation and noted that the resident had an ulcer on his coccyx. In-service training was also provided that day on bed mobility, wheelchair transfers and safety, falls and repositioning. Resident #1's nursing progress notes were reviewed on 2/19/10, at 5:07 p.m. to determine the resident's progress after his readmission to the group home, and revealed the following information: a. 1/15/2010 - (Nursing readmission progress note): The section on skin condition noted: "Skin: Left upper chest wall incision well healed. No s/s infection. Left upper arm former PICC line site benign"...."The PCP was made of aware of	I 401		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES		STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 401	<p>Continued From page 11</p> <p>[resident's] discharge back to the group home. Follow-up with PCP next week.</p> <p>b. 1/17/2010 - the nurse documented, "skins intact...continue to monitor."</p> <p>The review of nursing progress notes on 2/19/2010 at 4:55 p.m. also revealed the following information concerning an alteration in Resident #1's skin integrity:</p> <p>a. 1/20/2010 at 3:00 p.m., (LPN progress note) - "Staff reported sacral skin issue, non-bleeding, with discoloration. [Resident] will see PCP on 1/21/2010 (LPN) (3:30 p.m.) - Sacral area cleaned and treated with A & D ointment. Staff aware to report s/s of distress and to provide the proper skin care."</p> <p>b. 1/20/2010 at 8:15 p.m. (nursing progress note) - "Notified of gluteal breakdown this evening. Staff instructed to turn and reposition every 2 hours. Area cleaned with soap and water, and then patted dry. A& D ointment skin protectant applied. To see PCP in a.m." Staff was instructed to turn the resident from left to right every two hours in his bed and to not leave him in his wheelchair for more than one hour, except when on appointments.</p> <p>c. 1/21/2010, 5:40 p.m. (nursing progress note) - "Sacral wound observed with 100% yellowish tissue. Tissue presents as slough @ present. Wound unstageable @ present...wound edges even; periphery darkened. Wound without exudate or tunneling. Bactroban per orders and cover with gauze. Direct care staff instructed to turn resident every two hours. When in bed, to be turned every two hour to left and right trochanter. Completely relieve of all pressure</p>	I 401	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, 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 401	<p>Continued From page 12 when in bed."</p> <p>d. 1/23/2010 (nursing progress note) - "Wound care treatment to sacral ulcer stage II as ordered...yellowish tissue was noted on wound....no exudate or odor were noted. Treated as ordered."</p> <p>At the time of the survey, there was no evidence timely preventive measures had been established for Resident #1 at the time of his readmission to his group home, to minimize the risk of alteration in skin integrity.</p>	I 401		
-------	--	-------	--	--