

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/11/2010
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NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>1. On November 30, 2009, at approximately 12:15 a.m. the State Survey Agency (SSA) was notified by an anonymous letter (via facsimile) alleging that on September 20, 2009, the Provider had a fire. The letter further detailed that the Provider failed to have sufficient staff at the time of the fire. According to the anonymous complainant, the cause of the fire was attributed to the Provider improperly storing flammable items in the laundry area. The letter further alleged that Provider was not properly training staff in infection control procedures, handling of body fluids and using household chemicals.</p> <p>Due to the nature of the allegations and the information obtained from the administrative review, an investigation [#10-013] was initiated on December 4, 2009 and was completed on January 11, 2009. The findings of the investigation were based on environmental observations, interviews with group home management staff, direct care staff, and the review of administrative records.</p> <p>The investigation did not substantiate the complainant's allegations that:</p> <ol style="list-style-type: none"> 1. The facility was storing flammable items in the laundry area; 2. The facility had not trained staff on infection control procedures; 3. The facility had not trained staff on handling body fluids; and 4. The facility had not trained staff on the correct usage of household chemicals. 	W 000	<p>W000</p> <p>BRA did attempt to ascertain the cause of the fire but was not able to do so based on the evidence available and the circumstances created (i.e. immediate intervention and investigation) by the fire department. The investigation report submitted by BRA may not have been clear enough in outlining the efforts to ascertain cause. If such a circumstance were to occur in the future, BRA would insure that its investigation summary addressed the specifics of follow up as it pertains to the cause itself... 2-1-10.</p> <p>It must be noted that on the date of the fire, the investigating Sergeant from the Fire Investigation Unit, upon completing his review of the situation, stated that the fire <u>was not caused by build up on the lint filter</u>. He stated in fact that the "Lint filter was clear..." He noted that the filter showed no build up and was not burnt; the clothing in the dryer was not burned and so on. He stated as well that "Your systems worked..." (Meaning: the sprinkler system, evacuation protocol, notification protocol and so forth). BRA has received the final report from the fire department. There was no mechanical failure as the cause of the fire. All fire safety requirements were in place.</p> <p>In terms of re-training of staff, re-training and training generally on fire safety is done specific to home, specific to the dynamics a particular grouping presents (for example, in terms of evacuation support needed) and specific to the fire safety equipment in place, which may differ in type and location from home-to-home. Fire and safety retraining could not be done until system repairs and upgrades were completed and when the return to the home was imminent. The company providing sprinkler system support provided training to key staff on the sprinkler system upgrades and other upgrades on... 12-2-09.</p> <p>BRA's fire safety consultant provided training for all staff on the updated Safety Manual and on all safety concerns on... 1-21-10.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronald Johnson, Program Director</i>	TITLE <i>Program Director</i>	(X6) DATE <i>1/11/10</i>
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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

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W 000	<p>Continued From page 1</p> <p>Although the Provider investigated what occurred during the fire, there was no investigation directed on the cause of the fire. The e-mail received from another government agency suggested that the fire was caused by an overstuffed lint trap. On September 20, 2009, due to the severe property damage, the residents were relocated to a hotel. On December 4, 2009, the surveyor visited the facility and observed that the facility had been renovated; however the residents were not allowed to return because the Fire Marshall's office had not approved the sprinkler system.</p> <p>The SSA investigation determined there was no evidence that facility staff had been retrained on fire safety procedures nor was there evidence that the Safety Policy had been reviewed or revised.</p> <p>II. On December 1, 2009 at approximately 9:00 a.m., interview with the Qualified Mental Retardation Professional (QMRP) and the facility's Incident Management Coordinator (IMC) revealed that one client, who was residing temporarily at a hotel, was prevented from masturbating by facility's staff tying together at bedtime. Due to the nature of this practice, the incident was investigated on December 1, 2009 through December 9, 2009. The results of the investigation revealed the following:</p> <ol style="list-style-type: none"> 1. Client #1 and Client #2 unconsensually shared a king size bed from October 2009 to November 30, 2009. 2. Client #1's undergarments were tied together on November 23, 2009, preventing him from masturbating in the bed that he shared with Client 	W 000	<p>II. The staff member in question violated BRA policy both in creating physical restraints to prevent masturbation by Client number one and by putting Client #1 and #2 in bed together after the room switch. A sofa bed was provided in the new room and staff was specifically instructed to have Client #1 sleep in the bed and Client #2 on the sofa bed.</p> <p>Staff members #1 and #2 have been terminated for rights violations and failure to follow BRA and DDS policy on rights and abuse/neglect... 2-1-10.</p>		

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W 000	Continued From page 2 #2.	W 000			
	3. Client #1's undergarments were tied together to prevent him from ejaculating and urinating on Client #2.				
	4. Client #1's penis was observed by staff to be "excessively red" from masturbating all day. The discoloration in the resident's penis was not reported to the facility's administration facility's medical professionals or to the SSA.				
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102			
	This CONDITION is not met as evidenced by: Based on observation, interview and record review the facility's governing body failed to maintain general operating direction over the facility. [See 104].				
	The effects of these systemic practices resulted in the facility's Governing Body failure to adequately govern the facility in a manner that would ensure each client's health and safety. [See also W122]				
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104			
	This STANDARD is not met as evidenced by:				
			W102 The deficiencies cited under W102 have been addressed as evidenced by the responses to W104 and W122.		

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W 104	<p>Continued From page 3</p> <p>Based on interviews and record reviews, the governing body failed to exercise general policy and operating direction over the facility for one of the six clients residing in the facility. (Client #1)</p> <p>The findings include:</p> <p>I. The governing body failed to ensure that hotel accommodations ensured clients' rights to privacy and to prevent abuse as evidenced below:</p> <p>A. On December 4, 2009, at approximately 12:09 p.m., the Qualified Mental Retarded Professional (QMRP) escorted the investigator to the hotel in which the clients were temporarily residing. Observation of the rooms at approximately 12:20 p.m. revealed that Client's #1 and #2 were sharing a king size bed in the hotel. Further observation revealed that there was a sleeper sofa and a chair in the same suite. According to the QMRP the clients were initially reserved rooms (number 103 and 105) which had two queen size beds, a bed for each client. Further interview with the QMRP revealed that a popular concert was held at the near-by stadium and the hotel manager informed them that prior reservations were made for the rooms and the clients had to be relocated to a new room with a king size bed and a sleeper sofa.</p> <p>Interview with the hotel manager at approximately 11:50 a.m., confirmed that the clients changed rooms in early October 2009 to the new room because of a concert being held at the end of October. The interview further disclosed that the provider agreed to the room relocation. The hotel manager could not provide an actual date of the room change. The manager however confirmed that the reservation for the group home began on</p>	W 104	<p>W104</p> <p>A. Staff members #1 and #2 were terminated for rights violations and failure to follow BRA and DDS policy. All staff has been re-trained on the Human Rights policy and abuse/neglect...2-1-10. Additionally, staff has been re-trained on the specific issue of masturbation (Client #1) by nursing with the focus on privacy, personal hygiene, infection control and human rights...2-1-10.</p>		

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W 104	<p>Continued From page 4</p> <p>September 21, 2009. The manager explained that the clients have been living in the hotel for approximately 2 1/2 months.</p> <p>B. On December 3, 2009, at approximately 10:45 a.m., interview with Staff #2 revealed that he tied Client #1's shirt and undered pants together because he was sharing a king size bed with Client #2. Staff #2 explained that Client #1 masturbates and when he ejaculates, he also urinates all over himself and the bed. To prevent Client #2 from being subjected to Client #1's bodily fluids, Staff #2 tied Client #1's underpants to his under shirt to prevent him from masturbating. Staff #2 stated that he "did not tie the client's shirt and underpants to hurt him" and further commented, "I would not hurt anyone. I am one of the shift supervisors."</p> <p>C. Client #1 has a behavior of masturbating in public. The client's behavior management plan (BMP) indicated that the client is required to be directed to his bed when he begins to masturbate. The governing body failed to ensure that his hotel bedroom could accommodate the strategies outline in his BSP.</p> <p>2. The governing body failed to investigate the nature of the fire as recommended by their Incident Management Coordinator and Administrator. It should be noted that the SSA was initially informed by the another government agency that the fire was caused by lint in the dryer unit.</p> <p>3. The governing body failed to ensure facility staff had been retrained on fire safety procedures.</p>	W 104	<p>The QMRP and home manager will spot check the overnight shift at minimum once weekly to insure that procedures are being routinely followed.</p> <p>B. A protocol is being developed to formalize the existing every two hours incontinence checks that occur for client #1 nightly and data will be collected nightly on incontinence... 2-1-10. The protocol will also require checks for ejaculations. Individual clean up will be assisted if this occurs as well.</p> <p>Hotel stays will result in the development of a protocol for staff to follow outlining all of the key duties and responsibilities for staff and will specifically address the issue of sleeping arrangements. The protocol will be clear; at no time are individuals supported to sleep in the same bed... 2-1-10. The QMRP and other management staff will perform daily checks of the overnight shift to make sure prescribed protocols are being followed... 2-1-10.</p> <p>C. Psychology will provide follow up training on the BSP giving specific attention to the masturbation issue... 2-7-10.</p> <p>2. As stated earlier, BRA did try to ascertain the cause of the fire but could not. BRA will insure in the future that it clearly documents such efforts in the investigation report... 2-1-10. Also as stated earlier, the Fire Inspector on the night of the fire indicated that the fire was not caused by build up on the lint filter. He indicated that the lint filter was clear... 2-1-10.</p> <p>BRA will continue to enforce its existing policy concerning use of the dryer which calls for staff to check the lint filter before and after each use but BRA will begin to document these checks via a standard form beginning 2-5-10. In addition, staff will insure that the laundry room is maintained clutter free to reduce the likelihood of a fire... 2-1-10. The dryer has been replaced... 2-1-10.</p>		

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W 104	Continued From page 5 On November 30, 2009, at approximately 12:15 a.m. the SSA was notified by an anonymous letter (via facsimile) alleging that on September 20, 2009, the Provider had a fire. The letter further detailed that the Provider was insufficiently staffed at the time of the fire. According to the anonymous complainant, the cause of the fire was attributed to the Provider improperly storing flammable items in the laundry area. An e-mail received from another government agency suggested that the fire was caused by an overstuffed lint trap. At the time of the investigation, there was no evidence that the governing body had ensured facility staff had been retrained on fire safety procedures nor was there evidence that the Safety Policy had been reviewed or revised.	W 104	3. Staff was re-trained by the Fire Safety Consultant on... 1-21-10. As indicated in the survey report, sufficient staff was on duty the night of the fire, there was no improper storage of flammable items and as indicated twice earlier, BRA was informed by the Fire Inspector on site the night of the fire, that the lint trap was not overstuffed but rather, "Was clear..." 2-1-10. BRA's fire safety consultant revised the BRA Safety Manual to reflect the modifications in the system and the home repairs (post fire). He submitted the revised version to BRA on... 1-14-10 and re-trained staff on its mandates on... 1-21-10.		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review the facility failed to ensure that clients were provided opportunities for personal privacy [Cross reference W129]; failed to ensure that measures were developed and implemented to ensure clients' rights and to prevent mistreatment and abuse [Cross reference W149]; failed to ensure that all allegations of mistreatment, neglect or abuse, are reported immediately to the administrator and to other officials [Cross reference to W154]; failed to protect clients from further potential restraints and abuse while the investigation was in progress [Cross reference to	W 122			

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W 122	Continued From page 6 W155]; failed to ensure the administrator reviewed investigations within five working days of the incident [Cross reference W156].	W 122	W122 The issues cited under W122 have been addressed as evidenced by the responses for W129, W149, W154, W155 and W156.	
W 129	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that clients were provided opportunities for personal privacy for two of the six clients in the facility. The finding includes: Interview with Client #1's one to one staff on December 4, 2009, revealed that Client #1 masturbated in his bed at night. Further interview with staff revealed that Client #1 shared a bed with Client #2 while he was relocated to a hotel from October 2009 to December 2009. The staff reported that he tied the client's underpants and tee-shirt together to prevent the behavior from occurring during the night. He further indicated that it was not his intention to harm the client, but to prevent him from urinating on himself and Client #2, which is a practice that occurs after ejaculation. On December 4, 2009, at approximately 1:20 p.m., review of Client #1's behavior management plan (BMP), dated May 3, 2009,	W 129	W129 The staff committing these acts was terminated and all remaining staff has been re-trained on rights and abuse/neglect... 2-1-10. All new staff will receive this training during their orientation consistent with the new DDS training requirements... 2-1-10. BRA is purchasing a room divider to better provide Client #1 with privacy at home... 2-5-10.	

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W 149	Continued From page 8 [See W129] 2. Staff #2 indicated in his interview on December 4, 2009, at approximately 11:15 a.m., that on November 23, 2009, Client #1 was masturbating throughout the evening shift and as a result his penis was observed extremely red. On December 9, 2009, at approximately 1:30 p.m., review of the behavior data collection and nursing notes failed to provide any evidence that the client's masturbation behaviors from October 2009 to December 2009 and the condition of the client's penis on November 23, 2009, were reported or documented. 3. Staff interview on the December 4, 2009, reported that during the night, Client #1 masturbates, and upon ejaculation, he would urinate "all over himself" and the bed. To prevent this behavior and to prevent Client #2 from Client #1's bodily fluids, the staff tied Client #1's underpants and tee-shirt together. Although this practice was observed on November 24, 2009, at the time of the investigation, the facility had not completed their internal investigation. Additionally, there was no evidence that the facility took proactive action to prevent further potential harm/abuse while the incident was being investigated. On December 4, 2009, Client #1 and Client #2 continued to share one bed while residing in a hotel room.	W 149	2. As mentioned, staff failed to report the condition of Client #1's penis but when it was examined by nursing there was no evidence of redness, soreness or any other damage. Staff, including nursing personnel was interviewed and no one has ever seen evidence of Client #1 masturbating to the point of hurting himself or even causing redness... 2-1-10. A protocol will be developed that instructs staff in supporting the masturbation activity. Staff will support Client #1's right to do so in private but will monitor for any signs of damage. Should any signs be seen, that will be immediately reported to nursing who will in turn inform the PCP. If the PCP determines that the activity at that point is harmful and therefore self-abusive at that point, a protocol to prevent the behavior will be implemented for a period of time prescribed by the PCP. This protocol will be presented to the HRC for approval prior to being implemented. Protocol developed by... 2-5-10. Presented to HRC by... 2-10-10 Staff trained by... 2-15-10.		
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	W 153			

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W 153	<p>Continued From page 9 established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of mistreatment, neglect or abuse, are reported immediately to the administrator and to other officials in accordance with State law for one of six clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>[Cross Reference W129 and W149] On December 1, 2009, at approximately 9:00 a.m., interview with the Qualified Mental Retardation Professional (QMRP) and the facility's Incident Management Coordinator (IMC) revealed that an incident had occurred with Client #1 while residing in a hotel temporarily.</p> <p>According to the IMC, on November 24, 2009, Staff #1 stated that when he arrived to his shift on November 23, 2009, Staff #2 reported that he had tied Client #1's undergarments together to prevent him from masturbating. In addition, Staff #2 reported the client's penis was excessively red the night before, however failed to report it to any medical/nursing staff or to the facility's administrator.</p> <p>The IMC stated the agency has a "Chain of Command Policy that should be followed when an incident occurs and /or change in the client's health status is observed." However, acknowledged that the staff failed to report the incident timely in accordance with agency policy. Staff #1 was instructed at that time to write an unusual incident report.</p>	W 153	<p>W153</p> <p>As stated, the QMRP received verbal feedback on 11-24-09 and she immediately required the staff member to come to complete an incident report. The staff member did not come to the office to do so until 11-27-09. The QMRP could not submit a report based on the verbal feedback because the information provided was too unclear and sketchy. It took the QMRP and IMC until 11-27-09 to get accurate information because staff #1 and #2 became reluctant reporters when the implications of their actions were explained by the QMRP and IMC...2-1-10. In the future, BRA will insure that an incident report is submitted with as much information as possible, while the remaining information is being ascertained...2-1-10.</p>		

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W 153	Continued From page 10	W 153			
W 154	<p>Although the facility completed an unusual incident report on November 24, 2009, the IMC notified DOH/HRLA November 27, 2009 (a total of 4 days later).</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an allegation of abuse was investigated for one of the six clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on December 4, 2009, 9:45 a.m., revealed the facility failed to timely investigate the following incident:</p> <p>An interview with the Incident Management Coordinator (IMC) revealed that she received a call informing her that an incident of improper use of restraint was reported to the QMRP during Staff #1's counseling session on November 24, 2009. Reportedly, Staff #1 was being reprimanded for not following the agency's "Overnight Call in Policy." According to the IMC, Staff #1 was being counseled by the QMRP and blurted out that Staff #2 had restrained Client #1. Further interview with the IMC revealed that Staff #1 was informed by Staff #2 on November 23, 2009, prior to departing his shift, that he "tied up</p>	W 154	<p>W154</p> <p>Similar to the above in W153, it simply took the IMC and QMRP longer than 5 days to extract the information from the key witnesses who became reluctant reporters because both were guilty of policy violations. BRA undertook the investigation immediately but the lack of cooperation initially by the two staff members stretched out the process beyond the 5 days prescribed. In the future, faced with similar circumstances, BRA will provide a preliminary report at the 5 day mark while continuing to investigate fully, promising full disclosure upon completion of the investigation if one extends beyond 5 days...2-1-10.</p>		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/11/2010
NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1034 BURNS ST., SE WASHINGTON, DC 20019		
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W 154	Continued From page 11 Client #1's tee shirt and underwear" before allowing him to go to bed. Reportedly, the IMC stated that Staff #1 failed to report the incident to any management staff on the day it was reported to him, on November 23, 2009, when he came on duty. Interview with Staff #1 revealed that he found Client #1's shirt was tied to his underwear and he untied him. He did not however contact the management staff as required by the agency's Chain of Command Policy and failed to notify management staff of Staff #2's acknowledgement of his unauthorized use of restraint.	W 154			
W 155	At the time of the on-site investigation on December 4, 2009, (11 days after the incident) the IMC failed to have the internal investigation completed. 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to protect clients from further potential restraints and abuse while the investigation was in progress for 2 of 6 clients residing in the facility (Client #1 and Client #2). The finding includes: [Cross Refer to W153] Interview with the Qualified Mental Retardation Professional on December 4, 2009, at approximately 3:30 p.m., revealed that both Client #1 and #2 remained in	W 155			
			W155 Staff member #2 was not assigned to hotel coverage after 11-24-09 as evidenced by BRA's call in logs submitted with this response document... 2-1-10. Both staff members were replaced for hotel coverage after 11-24-09.		

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W 155	Continued From page 12	W 155			
W 156	<p>the same hotel room with one bed. Although the QMRP and the direct care staff indicated that Client #1 sleeps on the pull out sofa, Staff #2 remained as the assigned staff for Client #1 until December 3, 2009, 10 days, after the reported incident of unauthorized restraints/abuse.</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the administrator reviewed investigations within five working days of the incident, for one of the six clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to report the investigation findings to the administrator within five working days in accordance with the agency policies as evidenced below:</p> <p>On November 30, 2009, at approximately 12:15 a.m. the State Survey Agency (SSA) was notified (via facsimile) by an anonymous letter alleging that on September 20, 2009, a fire started at this facility. The letter further detailed that this facility was short staffed at the time of the fire incident. According to the anonymous complainant, the cause of the fire was attributed to the facility's staff were improperly storing flammable items in the laundry area. Finally, the letter described</p>	W 156	<p>W156</p> <p>As stated, the QMRP received verbal feedback on 11-24-09 and she immediately required the staff member to come to complete an incident report. The staff member did not come to the office to do so until 11-27-09. The QMRP could not submit a report based on the verbal feedback because the information provided was too unclear and sketchy. It took the QMRP and IMC until 11-27-09 to get accurate information because staff #1 and #2 became reluctant reporters when the implications of their actions were explained by the QMRP and IMC... 2-1-10. In the future, BRA will insure that an incident report is submitted with as much information as possible, while the remaining information is being ascertained... 2-1-10.</p>		

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W 189	Continued From page 14 2. [Cross-refer to W129] The facility failed to effectively train staff on Clients rights to ensure privacy and to prevent abuse. 3. [Cross-refer to W104] The facility failed to effectively train staff on fire safety procedures.	W 189	Rights, privacy and preventing abuse/neglect have been completed... 2-1-10. Fire safety was completed... 1-21-10. New staff receives all of the above required trainings during their orientation consistent with DDS' new policy... 2-1-10. Additionally, staff is retrained annually. A 2010 training calendar will be developed that is consistent with DDS' requirements by... 2-7-10.		

Health Regulation Administration

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1 000	<p>INITIAL COMMENTS</p> <p>1. On November 30, 2009, at approximately 12:15 a.m. the State Agency (SA) was notified by an anonymous letter (via facsimile) alleging that on September 20, 2009, the Provider had a fire. The letter further detailed that the Provider was short staffed at the time of the fire. According to the anonymous complainant, the cause of the fire was attributed to the Provider improperly storing flammable items in the laundry area. The letter also described the Provider was not properly training staff in the infection control procedures, properly handling of bodily fluids and using of household chemicals.</p> <p>Due to the nature of the allegations and the information obtained from the administrative review, an investigation [#10-013] was initiated on December 4, 2009 and completed on December 9, 2009. The findings of the investigation were based environmental observations, interviews with group home management staff, direct care staff, and the review of administrative records.</p> <p>The investigation did not substantiate the complainant's allegations that the Provider was:</p> <ol style="list-style-type: none"> 1. The facility was storing flammable items in the laundry area; 2. The facility had not trained staff on infection control procedures; 3. The facility had not trained on handling bodily fluids; and 4. The facility had not trained staff on correct usage of household chemicals. <p>Although the cause of the fire could not be</p>	1 000	<p>BRA did attempt to ascertain the cause of the fire but was not able to do so based on the evidence available and the circumstances created (i.e. immediate intervention and investigation) by the fire department. The investigation report submitted by BRA may not have been clear enough in outlining the efforts to ascertain cause. If such a circumstance were to occur in the future, BRA would insure that its investigation summary addressed the specifics of follow up as it pertains to the cause itself... 2-1-10.</p> <p>It must be noted that on the date of the fire, the investigating Sergeant from the Fire Investigation Unit, upon completing his review of the situation, stated that the fire was not caused by build up on the lint filter. He stated in fact that the "Lint filter was clear..." He noted that the filter showed no build up and was not burnt; the clothing in the dryer was not burned and so on. He stated as well that "Your systems worked..." (Meaning: the sprinkler system, evacuation protocol, notification protocol and so forth). BRA has received the final report from the fire department. There was no mechanical failure as the cause of the fire. All fire safety requirements were in place.</p> <p>In terms of re-training of staff, re-training and training generally on fire safety is done specific to home, specific to the dynamics a particular grouping presents (for example, in terms of evacuation support needed) and specific to the fire safety equipment in place, which may differ in type and location from home-to-home. Fire and safety retraining could not be done until system repairs and upgrades were completed and when the return to the home was imminent. The company providing sprinkler system support provided training to key staff on the sprinkler system upgrades and other upgrades on... 12-2-09.</p> <p>BRA's fire safety consultant provided training for all staff on the updated Safety Manual and on all safety concerns on... 1-21-10.</p>	

Health Regulation Administration

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

TITLE
[Signature]
ME3K11

(X6) DATE
[Signature] 01/10
If continuation sheet 1 of 5

Health Regulation Administration

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I 000	Continued From page 1 substantiated, the State Surveying Agency (SSA) confirmed that a fire, which caused severe property damage, occurred on September 20, 2009. The incident report received by the SSA suggested that the fire was caused by an overstuffed lit trap. On September 20, 2009, due to the severe property damage, the residents were relocated to a hotel. On December 4, 2009, the surveyor visited the facility and observed that the facility had been renovated; however the residents were not allowed to return because the Fire Marshall's office had not approved the sprinkler system. II. On December 1, 2009, approximately at 9:00 a.m., interview with the Qualified Mental Retardation Professional (QMRP) and the facility's Incident Management Coordinator (IMC) revealed that one resident, who was residing temporarily at a hotel was prevented from masturbating as his undergarments were tied together at bedtime. Due to the nature of this practice, the incident was investigated on December 1, 2009 through December 9, 2009. The results of the investigation revealed the following: 1. Resident #1 and Resident #2 unconsensually shared a king size bed from October 2009 to November 30, 2009. 2. Resident #1's undergarments were tied together on November 23, 2009 preventing him from masturbating in the bed that he shared with Resident #2. 3. Resident #1's undergarments were tied together to prevent him from ejaculating and urinating on Resident #2.	I 000	II. The staff member in question violated BRA policy both in creating physical restraints to prevent masturbation by Client number one and by putting Client #1 and #2 in bed together after the room switch. A sofa bed was provided in the new room and staff was specifically instructed to have Client #1 sleep in the bed and Client #2 on the sofa bed. Staff members #1 and #2 have been terminated for rights violations and failure to follow BRA and DDS policy on rights and abuse/neglect... 2-1-10.	

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1 000	Continued From page 2 4. Resident #1's penis was observed by staff to be "excessively red" from masturbating all day. The discoloration in the resident's penis was not reported to the facility's administration facility's medical professionals or to the SSA.	1 000		
1 222	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 interviews, and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for one of the six residents residing in the facility. (Resident #1) The finding includes: 1. [Cross-refer to W149] The facility failed to ensure that all facility staff received effective training that included implementation of the incident management policy. 2. [Cross-refer to W129] The facility failed to effectively train staff on Client's rights to ensure privacy and to prevent abuse. 3. [Cross-refer to W104] The facility failed to effectively train staff on fire safety procedures.	1 222	The staff committing these acts was terminated and all remaining staff has been re-trained on rights and abuse/neglect...2-1-10. All new staff will receive this training during their orientation consistent with the new DDS training requirements...2-1-10. BRA is purchasing a room divider to better provide Client #1 with privacy at home...2-5-10.	
1 379	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	1 379		

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I 379	<p>Continued From page 3</p> <p>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 twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of mistreatment, neglect or abuse, are reported immediately to the administrator and the Department of Health (DOH), Health Regulation Administration, for one of six clients residing in the facility. (Resident #1)</p> <p>The finding includes:</p> <p>On December 1, 2009, approximately 9:00 a.m., interview with the Qualified Mental Retardation Professional (QMRP) and the facility's Incident Management Coordinator (IMC) revealed that an incident had occurred with Resident #1 while residing in a hotel temporarily.</p> <p>According to the IMC, on November 24, 2009, Staff #1 stated when he arrived to his shift on November 23, 2009; Staff #2 had informed that he had tied Resident #1's undergarments together to prevent him from masturbating. In addition, Staff #1 reported the resident's penis was "excessively red" the night before, however failed to report it.</p> <p>The IMC stated the agency has a "Chain of Command Policy that should be followed when an incident occurs and /or change in the client</p>	I 379	<p>Even after the room switch two beds were available, one being a sofa bed that pulled out and staff was instructed to have Client #1 sleep in the master bed and Client #2 on the sofa bed. Staff did not follow instructions and the violation was not discovered during management oversight visits. Staff has been terminated... 2-1-10.</p> <p>The CEO has met with the QMRP to insure that it is understood that sleeping arrangements and all other protocols outlined for a hotel stay must be monitored for all shifts during such a stay. In the future compliance will be monitored daily for all shifts via QMRP visits and other management staff visits... 2-1-10.</p> <p>2. As mentioned, staff failed to report the condition of Client #1's penis but when it was examined by nursing there was no evidence of redness, soreness or any other damage. Staff, including nursing personnel was interviewed and no one has ever seen evidence of Client #1 masturbating to the point of hurting himself or even causing redness... 2-1-10.</p> <p>A protocol will be developed that instructs staff in supporting the masturbation activity. Staff will support Client #1's right to do so in private but will monitor for any signs of damage. Should any signs be seen, that will be immediately reported to nursing who will in turn inform the PCP. If the PCP determines that the activity at that point is</p> <p>As stated, the QMRP received verbal feedback on 11-24-09 and she immediately required the staff member to come to complete an incident report. The staff member did not come to the office to do so until 11-27-09. The QMRP could not submit a report based on the verbal feedback because the information provided was too unclear and sketchy. It took the QMRP and IMC until 11-27-09 to get accurate information because staff #1 and #2 became reluctant reporters when the implications of their actions were explained by the QMRP and IMC... 2-1-10. In the future, BRA will insure that an incident report is submitted with as much information as possible, while the remaining information is being ascertained... 2-1-10.</p>	

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I 379	<p>Continued From page 4</p> <p>health status is observed. " However, acknowledged that the staff failed to report the incidents timely in accordance with agency policy. Staff #1 was instructed at that time to write an unusual incident report.</p> <p>Although the facility completed an unusual incident report on November 24, 2009, the IMC notified DOH/HRLA November 27, 2009 (a total of 4 days later).</p>	I 379		