STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G071	A. BUILDING _____ B. WING _____	06/19/2009

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BEHAVIOR RESEARCH ASSOCIATES	1034 BURNS ST., SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 17, 2009 through June 19, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of six males with various disabilities. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports.	W 000	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 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that client's involved family members and/or legal guardians were notified of significant incidents, for two of three client's included in the sample. (Clients #1 and #2) The finding includes: Interview with the Acting House Manager (HM) on June 17, 2009, at approximately 1:00 PM revealed Client's #1 and #2 had a legal guardian that were involved in their habilitation and care. The facility's incident reports and corresponding investigations were reviewed on the same day,	W 148	W148 The legal guardians of client #1 and #2 were in fact notified about the incidents as the IMC indicated but all parties involved failed to insure that the notifications were noted on the incident report forms or in the summaries. In the future, the IMC, QMRP and Program Director will perform final reviews of any incident report and investigation summary to insure that there are no future omissions of this type...7-10-09.	

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

Linda R. Graham, QMRP Coordinator 07/08/09

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 148	Continued From page 1 beginning at 3:07 PM. a. According to an incident/investigation report dated February 13, 2009, Client #1 was taken to the hospital emergency room for x-rays of his left swollen ankle on February 13, 2009. Interview with the Incident Management Coordinator (IMC) on June 18, 2009, at approximately 9:00 AM, revealed Clients #1's guardian was notified on the swollen right ankle. At the time of the survey, however, there was no documented evidence of notification to the guardian on the incident report. b. An incident/investigation report documented that on April 8, 2009, Client #2 was not eating dinner and had a temperature of 102 degrees. The client was taken to the hospital vial 911. Interview with the IMC on July 18, 2009, at approximately 9:05 AM, revealed Clients #2's guardian was notified of the emergency room visit. At the time of the survey, however, there was no documented evidence of notification to the guardian on the incident report.	W 148		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for three of the six clients residing in the facility. (Clients #1, #2 and #4)	W 159	W159 1. All staff has been retrained on the proper seating for Client #1 and all individuals supported during van travel. In addition, the home manager will make routine observations before departures and upon arrivals to insure that there is routine compliance...7-10-09. 2. See responses for W186. 3. See responses for W189 4. See responses for W193	

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W 159	Continued From page 2 The findings include: 1. The QMRP failed to ensure that staff implemented the recommendations made by the Incident Management Coordinator (IMC) for Client #1 as evidenced below: On June 17, 2009, beginning at 3:07 PM, review of the facility's incident and corresponding investigation reports were reviewed. An investigation report dated April 23, 2009, revealed that Client #1 sustained a physical injury to his right knee by bumping it on the back driver's seat when getting out of the van. Further review of the investigation revealed a recommendation for Client #1 "not to sit directly behind the driver seat." At approximately 4:06 PM, Client #1 arrived home from day program with his 1:1 staff. Client #1 was observed sitting directly behind the driver seat. On June 18, 2009, at approximately 9:15 AM, interview with the IMC revealed that she had trained all staff on the importance of Client #1 not sitting directly behind the driver seat. The IMC stated that she would retrain all staff again. 2. The QMRP failed to ensure sufficient direct care staff were on duty while the clients were transported to the their day program and/or medical appointments. [See W186] 3. The QMRP 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. [See W189]	W 159		

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W 159	Continued From page 3 5. The QMRP failed to ensure staff demonstrated competency in the implementation of the behavior support plans. [See W193] 6. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts. [See W440]	W 159		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure sufficient direct care staff were on duty while the clients were transported to their day program and/or medical appointments, for three of six clients residing in the facility. (Clients #1, #2, and #4) The findings include: 1. On June 17, 2009, at approximately 1:00 PM, Client #4 was observed to get on the facility's van (sat in middle seat) while his 1:1 staff got into the driver seat. At approximately 4:06 PM, Client #4 arrived home from the day program. The client was observed to exit the van from the middle seat while his 1:1 staff got out of the driver seat. Interview with Client #4's 1:1 staff revealed that he was one of the designated drivers for the morning/afternoon shift.	W 186	W186 1. BRA has hired a new staff driver and attendant. Travel coverage is now in compliance with the mandated ratios...7-8-09. In the future, BRA will insure that ratios are adequate by using part time staff, managers or staff performing overtime until staff vacancies are filled...7-10-09. BRA will move aggressively to fill all staff vacancies that occur in order to insure that support ratios are in compliance with individual needs at all times...7-10-09. 2. Individuals who do not have medical appointments will not leave there day programs early in the future. BRA will insure that arrangements are made that allow the appointment to be made while others are able to benefits from their given day services. At present, the vacancies that caused the issue have been filled. In addition, the QMRP, home manager and RN will meet monthly to plan all upcoming medical appointments and part of the planning process will include insuring that transportation needs are met without compromising the services of other individuals...7-10-09.	

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W 186	Continued From page 4 Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 5:00 PM, confirmed that Client #4's 1:1 staff transported clients to and from day program. Further interview with the QMRP revealed that the facility was short staff and that they were in the process of hiring more drivers. On June 18, 2009, at 4:10 PM, review of Client #4's medical records, revealed he had diagnoses of Intermittent Explosive Disorder and Autistic Disorder. Review of his Behavior Support Plan (BSP) dated March 28, 2009, revealed the client received 24-hour 1:1 staffing to ensure his safety during the day/night and to provide him with behavioral supports for his many targeted behaviors (i.e. physically explosive behaviors, reasonable staff requests, SIB, Agitation, striking of staff/peers, and repeatedly changing clothes) and also to ensure the safety of his peers. Further review of the BSP revealed that the positioning of the 1:1 staff should be at visual length from the client when he's calm and stable in behavior. Positioning of the 1:1 staff should also be at arms length when an incident involves SIB or explosive behavior. There was no evidence that the facility maintained a sufficient number of staff to ensure that Client #4 was monitored and to assist with his behavior management needs when transporting to and from the day program. 2. On June 17, 2009, at approximately 1:00 PM, Client #4 was observed walking out of the day program with his 1:1 staff. Clients' #1 and #2 was observed sitting in the lobby with Client #1's 1:1 staff. Interview with Client #1's 1:1 staff and the	W 186		

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W 186	Continued From page 5 day program's Case Manager (CM) revealed that Clients #1 and #4 were signed out early because Client #2 had a medical appointment. Further interview with the CM revealed all clients left early when one or more clients had medical appointments. On June 18, 2009, at 10:00 AM, interview with the QMRP confirmed that Client #2 had a medical appointment and that Clients #1 and #4 left the day program early. The QMRP acknowledged that staff coverage was currently an ongoing problem that was being addressed by interviewing more drivers.	W 186		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview 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 two of six clients in the sample. (Client #1 and #2) The findings include: 1. The facility failed to ensure that the direct care staff provided a seat cushion for Client #1 as recommended by the Physical Therapist as evidenced below: On June 17, 2009, at approximately 4:40 PM, The	W 189		

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W 189	Continued From page 6 1:1 staff was observed to assist Client #1 from his arm chair in the living room to the kitchen. At approximately 4:50 PM, Client #1 was assisted by his 1:1 staff to sit in the dining room for active treatment. At approximately 6:30 PM, Client #1 sat in the dining room again with assistance. Observation of the dining room area at 8:30 AM revealed the dining room chairs were hard and wooden. Further observations revealed Client #1 sat in the dining chair without a seat cushion. Record review conducted on June 18, 2009, at 3:45 PM, revealed a Physical Therapy Assessment dated October 28, 2008. According to the recommendation, Client #1 "required a seat cushion in his chair and dining room chair. Review of the staff in-service training book on June 19, 2009, at approximately 10:00 AM, revealed that all staff had received training on Client #1's Physical Therapy Assessment on October 31, 2008. There was no evidence that the training had been effective. 2. The facility failed to ensure that the direct care staff attached all adaptive equipment correctly as recommended by the nutritionist. Observation on June 17, 2009, at 4:20 PM, revealed the direct care staff placing a plate guard on Client #2's plate. The client was observed eating blueberry yogurt with the plate guard on the opposite side from where Client #2 was scooping. At 6:50 PM, Client #2 was observed eating dinner with the plate guard facing the opposite side, therefore half of the client's food was on the table. Record review conducted on June 18, 2009, at 2:44 PM, revealed a dining mealtime protocol	W 189	W189 1. Client #1's seat cushion was available but as indicated by the monitors, staff failed to provide it. Staff will be re-trained on providing the cushion and on the importance of consistently providing all needed adaptive equipment...7-20-09. 2. Again, the necessary equipment was available but staff failed to provide it for Client #2. These issues will also be covered in the upcoming training...7-20-09 In addition, the QMRP and home manager will observe meals at minimum twice weekly (each) to insure that staff routinely provide the supports required...7-20-09. It should be noted that staff has been routinely observed by management staff and generally perform appropriately consistent with their training. Staff was interviewed upon receipt of this survey document and was asked about the numerous performance issues that were evidenced during the survey. Most stated that they were, "Made nervous" by the survey process even though the monitors did nothing out of the ordinary to make them nervous. As a result, part of the re-training process for staff will be training to make them more comfortable during survey processes and to insure that they understand that they should follow their protocols, program guides and company procedures as per usual...7-20-09. 3. Staff will be retrained on assisting Client #2 with drinking. In addition, a protocol will be developed for staff to review routinely before undertaking the task...7-10-09.	

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W 189	Continued From page 7 dated July 7, 2008. According to the recommendation, Client #2 required a Hi-lo scoop plate, plate guard, slightly built-up handle spoon, dycem mat, wonderflocup and clothing protectors. Review of the staff in-service training book on June 19, 2009, at approximately 10:00 AM, revealed that all staff had received training on Client #2's adaptive equipment on November 13, 2008. There was no evidence that the training had been effective. 3. The facility failed to ensure that the direct care staff prompted Client # 2 to tilt his head as stated in the speech and language assessment. Observation on June 17, 2009, at 4:32 PM, revealed Client #2 drinking ensure. Half of the ensure was observed flowing out the client's mouth. Further observation revealed the direct care, hand feeding Client #2 his ensure. The ensure continued to flow out his mouth. Record review of the Speech and Language Assessment dated August 16, 2008, on June 18, 2009, at approximately 3:30 PM, stated Client #2 "has a history of maintaining an open mouth posture with some drooling noted. With his head tilted he is able to drink liquids from a spout cup". Review of the staff in-service training book on June 19, 2009, at approximately 10:00 AM, revealed that all staffs had received training on Client #2's Speech and Language Assessment on August 21, 2008. There was no evidence that the training had been effective.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.	W 193		

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W 193	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate competency in the implementation of client's Behavior Support Plan (BSP) for two of six clients residing in the facility. (Clients #1 and #4) The findings include: 1. The facility failed to ensure that Client #1's 1:1 staff remained in close proximity in accordance with his BSP as evidence below: On June 17, 2009, at 4:37 PM, review of the facility's incident/investigation reports revealed an incident dated June 18, 2008. According to the incident, Client #1's 1:1 staff was standing by the kitchen to see what was being served to the individuals for dinner while Client #1 was several feet away in the living room. Further review of the incident revealed the 1:1 staff turned around a proceeded back to his seat when he noticed Client #1 getting out of his seat. The 1:1 staff immediately ran over to Client #1 with his arms and hands extended to grab him. The client immediately lost his balance and fell back into a lamp, which stood about 5 feet tall. On June 18, 2009, at approximately 9:20 AM, interview with the Incident Management Coordinator (IMC) revealed that Client #1 received 1:1 staffing 24 hours a day to manage physical safety and maladaptive behaviors. (i.e. contracting his muscles and locking his joints which lead to a loss of his balance and results in falls, instances of not sure of his footing, aggressive outbursts characterized by pushing,	W 193	W193 1. The one-to-one staff member for Client #1 has been retained on the job description mandates and coverage mandates for Client #1…7-8-09. The QMRP and home manager will observe active treatment hours at least twice weekly (QMRP) and three times weekly (home manager) to insure that there is routine compliance. Any performance issues observed will be addressed by on –the-spot training and follow up…7-20-09. 2. Same as above (for Client #4's one-to-one)…7-20-09.	

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W 193	Continued From page 9 kicking staff, and placing hands or fingers in mouth) Further interview with the IMC revealed that one of the primary duties of the 1:1 staff person was to remain within eyesight and/or arms length of Client #1 at all times. On June 18, 2009, at 2:00 PM, review of Client 1#'s BSP dated October 28, 2008 confirmed the IMC's interview. There was no evidence that on June 18, 2008, the facility staff demonstrated competency in the implementation of the client's BSP. 2. The facility failed to ensure Client #4's 1:1 remained in close proximity in accordance with his BSP. On June 17, 2009, at approximately 1:00 PM, Client #4 was observed to get on the facility's van (sat in middle seat) while his 1:1 staff got into the driver seat. At approximately 4:06 PM, Client #4 arrived home from the day program. The client was observed to exit the van from the middle seat while his 1:1 staff got out of the driver's seat. Interview with Client #4's 1:1 staff revealed that he was one of the drivers for the morning/afternoon. [See W186]	W 193		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to ensure recommended laboratory studies were obtained, for one of the three clients in the sample. (Client #1)	W 325	W325 The RN has developed a quarterly schedule for obtaining Clonopin levels for Client #1…7-8-09. BRA lost its second RN and its most experienced support LPN. The Senior RN is catching up a number of concerns at present including those outlined on this survey. BRA has hired the needed nursing support to replace those who have departed…7-8-09.	

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W 325	Continued From page 10 The finding includes: The facility failed to ensure Client #1 received the recommended psychotropic laboratory quarterly study as evidence below: On June 17, 2009, at approximately 6:00 PM, Client #1 was administered Clonopin 1 mg. Interview with the Licensed Practical Nurse (LPN) indicated that the client received the aforementioned medication for behavior and anxiety. Review of the physician orders dated December 2008 revealed an order to obtain quarterly psychotropic laboratory study. Further review of the client's medical record revealed that the last laboratory study was conducted on October 3, 2008. On June 18, 2009, at 11:20 AM, interview with the Registered Nurse confirmed that Client #1 did not receive his quarterly psychotropic laboratory study for clonopin as recommended.	W 325		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure client's Health Care Management Plans (HCMP) were updated in accordance with nursing services for one of three clients included in the sample. (Client #3) The finding includes: 1. On June 17, 2009, at 1:57 PM, interview with	W 331	W331 1. Client #3's health management care plan will be updated to reflect the new Norvasc regimen by…708-09. The Senior RN is reviewing and updating all of the HMCPs for the Burns residents and will complete the task by…7-20-09. 2. The name plates on the medication trays have been updated…7-8-09. The RN and/or support nurses will audit the medication cabinets at minimum monthly and address all such concerns found…7-20-09.	

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W 331	Continued From page 11 the day program's physician revealed that on March 19, 2009, an incident report was written regarding Client #3's elevated blood pressure. The incident report revealed that Client #3's facility was contacted to pick him up from the day program. Further review of the incident report revealed the client's blood pressure was checked by the facility's Licensed Practical Nurse (LPN) and remained elevated. Client #3 was transported to the emergency room via the facility's van. On June 18, 2009, at approximately 10:31 AM, review of Client #3's medical records revealed the hospital discharge summary dated March 20, 2009. According to the summary, Client #3 was diagnosed with hypertension and was prescribed Norvasc 10 mg by mouth each morning. At approximately 10:40 AM, review of the current Physician's Orders confirmed that Client #3 was prescribed Norvasc 10 mg for hypertension. However, review of the HCMP dated December 3, 2008, did not reflect the diagnosis of Hypertension and the newly prescribed Norvasc medication. Later that day at approximately 3:30 PM, interview with the facility Registered Nurse (RN) stated that she was aware that Client #3's HCMP did not reflect his new diagnosis and medication change. The RN acknowledged that the HCMP needed to be updated. 2. The facility failed to maintain the client's name on the medication tray ensuring medication errors. Observation On June 17, 2009, at 5:30 PM, the License Practical Nurse (LPN) dispensed each	W 331		

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W 331	Continued From page 12 client's medication and placed it on the medication tray. Oberservation of the medication tray revealed names that were worn and difficult to read. Interview with Registed Nurse on June 18, 2009, at approximately 2:00 PM, confirmed that the client's names were difficult to read. Further interview revealed that labels will made for the medication tray.	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the health status was reviewed by the Registered Nurse (RN) staff on a quarterly or more frequent basis for two of the three clients included in the sample. (Clients #2 and #3) The findings include: 1. Review of Client #1's medical record on June 17, 2009, at 11:20 AM, revealed an annual nursing assessment dated December 5, 2008. Further review of the medical records revealed there was no quarterly nursing assessment completed since December 2008. On June 18, 2009, at approximately 3:00 PM, interview with the facility's supervisory Registered Nurse (RN) revealed that she was responsible for completing the quarterly nursing exams. The RN	W 336	W336 The Senior RN has developed a schedule outlining the quarterly assessment parameters for each person. As mentioned, she is catching up on some key responsibilities based on recent departures in the nursing core. Full staffing has been attained and nursing responsibilities are being addressed in proper time frames...7-8-09.	

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W 336	Continued From page 13 acknowledged that Client #1's quarterly nursing had not been completed since December 2008. 2. Review of Client #2's medical record on June 17, 2009, at 12:00 AM, revealed an annual nursing assessment dated December 3, 2008. Further review of the medical records revealed there was no quarterly nursing assessment completed since December 2008. On June 18, 2009, at approximately 3:05 PM, interview with the facility's supervisory RN revealed that she was responsible for completing the quarterly nursing exams. The RN acknowledged that Client #2's that the quarterly nursing had not been completed since December 2008.	W 336		
W 388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure labels on all drugs and biologicals for one of one treatment tube presented. The finding includes: On June 18, 2009, at approximately 1:30 PM, a tube of Protocream 2.5 was presented to the surveyor during an interview without a label. Interview with the Registered Nurse revealed that a label was on the box instead of the tube. However, there was no evidence of a box for the protocream 2.5. At the time of the survey, the facility failed to ensure that all drugs remained labeled at all times.	W 388	W388 The unlabeled Protocream has been discarded and replaced. Nursing will audit the topical creams as well as the by mouth medications during their monthly audits and will address such concerns as they are found. In addition, nursing will support quarterly pharmacy reviews and insure the same follow up for issues found during that process...7-20-09.	
W 440	483.470(i)(1) EVACUATION DRILLS	W 440		

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W 440	Continued From page 14 The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The finding includes: Interview with the House Manager (HM) on July 17, 2009 at 3:40 PM revealed the facility had five shifts of direct care personnel. The shifts were weekdays 8 AM - 4 PM, 4 PM - 12 AM, 12 AM - 8 AM and on weekends 8 AM - 8 PM and 8 PM - 8 AM. There was no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift from July 2008 to June 2009. Review of the fire drill log book on June 17, 2009, at approximately 3:43 PM, revealed there were no fire drills conducted from July 2008 to December 2008 for the 8 AM - 4 PM morning weekday shift. At approximately 4:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) acknowledged that fire drills were not conducted quarterly on each shift. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	W 440	W440 Make up fire drills have been scheduled to address the missed drills and those held without individuals served (present)...7-8-09. The home manager has been re-trained to insure that fire drills are held as prescribed by the standard schedule routinely. In addition, the QMRP will monitor monthly implementation and insure follow up for any failures to implement as prescribed or document properly...7-20-09.	
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.	W 454		

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W 454	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection for one of three clients included in the sample. (Client #2) The finding includes: On June 17, 2009, at 4:32 PM, Client #2 was observed at the dining table drinking ensure from a spout cup. At 4:35 PM, Client #2's spout cup fell to the floor. Several direct care staff were observed walking past the area in which the spout cup fell. One staff picked the spout cup up from the dining room floor and sat the cup back on the table. Client #2 reached over grabbed the cup and continued to finish drinking his ensure. Later interview with the direct care staff at approximately 5:15 PM, confirmed Client #2's spout cup did fall to the floor and was placed back on the table. The direct care staff acknowledged that she should have rinsed the spout cup off before placing it back onto the dining table.	W 454	W454 Staff will be re-trained on infection control with specific attention given to mealtime considerations...7-20-09. This consideration will be monitored during meal observations...7-20-09.	

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 17, 2009 through June 19, 2009. A random sample of three residents was selected from a resident population of six males with various disabilities. The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident and investigation reports.	I 000		
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP 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 six residents in the sample. (Resident #2) The findings include: 1. The GHMRP failed to ensure that the direct care staff attached all adaptive equipment correctly as recommended by the nutritionist. Observation on June 17, 2009, at 4:20 PM, revealed the direct care staff placing a plate guard on Resident #2's plate. The resident was observed eating blueberry yogurt with the plate	I 055	3502.13 1. Client #1's seat cushion was available but as indicated by the monitors, staff failed to provide it. Staff will be re-trained on providing the cushion and on the importance of consistently providing all needed adaptive equipment...7-20-09. 2. Again, the necessary equipment was available but staff failed to provide it for Client #2. These issues will also be covered in the upcoming training...7-20-09	

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I 055	Continued From page 1 guard on the opposite side from where Resident #2 was scooping. At 6:50 PM, Resident #2 was observed eating dinner with the plate guard facing the opposite side, therefore half of the client's food was on the table. Record review conducted on June 18, 2009, at 2:44 PM, revealed a dining mealtime protocol dated July 7, 2008. According to the recommendation, Resident #2 required a Hi-lo scoop plate, plate guard, slightly built-up handle spoon, dycem mat, wonderflocup and clothing protectors. Review of the staff in-service training book on June 19, 2009, at approximately 10:00 AM, revealed that all staffs had received training on Resident #2's adaptive equipment on November 13, 2008. There was no evidence that the training had been effective. 2. The GHMRP failed to ensure that the direct care staff prompted Resident # 2 to tilt his head as stated in the Speech and Language Assessment. Observation on June 17, 2009, at 4:32 PM, revealed Resident #2 drinking ensure. Half of the ensure was observed flowing out the resident's mouth. Further observation revealed the direct care hand feeding Resident #2 his ensure. The ensure continued to flow out his mouth. Record review of Speech and Language Assessment dated August 16, 2008, on June 18, 2009, at approximately 3:30 PM, stated Resident #2 "has a history of maintaining an open mouth posture with some drooling noted. With his head tilted he is able to drink liquids from a spout cup". Review of the staff in-service training book on June 19, 2009, at approximately 10:00 AM, revealed that all staffs had received training on	I 055		

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I 055	Continued From page 2 Resident #2's Speech and Language Assessment on August 21, 2008. There was no evidence that the training had been effective.	I 055		
I 081	3503.9 BEDROOMS AND BATHROOMS Each bathroom shall be equipped to facilitate training toward maximum self-help by residents including individuals with physical disabilities and shall have appliances, fixtures or devices which shall be appropriate to the needs of each person who lives and works in the This Statute is not met as evidenced by: Based on observation and interview, the GHRMP failed to ensure that the toileting and bathing facilities were appropriate in numbers and was maintained in good repair for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The finding includes: Observations and interviews on June 17, 2009, revealed that there are six residents residing in the group home. During the environmental walk-thru on June 19, 2009, at approximately 3:15 PM, observations of the bathroom on the second level of the GHMRP revealed that the toilet was not secured to the floor. The toilet was observed to be loose when barely touched. Interview with the Qualified Mental Retardation Professional confirmed that the toilet was loose. There was no evidence that the bathroom GHMRP had been consistently maintained in accordance with federal and state regulations.	I 081	3503.9 The loose toilet has been secured...7-8-09.	

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I 091	Continued From page 3	I 091		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHRMP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observation and interview with the House Manager during the environmental walk through on June 19, 2009, beginning at a approximately 3:15 PM, revealed the following. 1. The front right and rear burners located on the kitchen stove was observed to be inoperable. 2. The bedroom window screen located at the end of the hall was observed to be torn. Further observation revealed another window with a missing screen.	I 091	3504.2 1. The stove burners will be repaired by...7-10-09. 2. The bedroom window screens will be addressed by...7-10-09 The home manager will audit the environment and report such concerns for follow up weekly...7-20-09.	
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for six of six residents	I 135		

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I 135	Continued From page 4 residing in the GHMRP. (Residents #1, #2, #3, #4, #5, and #6) The finding includes: Interview with the House Manager (HM) on July 17, 2009 at 3:40 PM revealed the GHMRP had five shifts of direct care personnel. The shifts were weekdays 8 AM - 4 PM, 4 PM - 12 AM, 12 AM - 8 AM and on weekends 8 AM - 8 PM and 8 PM - 8 AM. There was no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift from July 2008 to June 2009. Review of the fire drill log book on June 17, 2009, at approximately 3:43 PM, revealed there were no fire drills conducted from July 2008 to December 2008 for the 8 AM - 4 PM morning weekday shift. At approximately 4:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) acknowledged that fire drills were not conducted quarterly on each shift.	I 135	3505.5 Make up fire drills have been scheduled to address the missed drills and those held without individuals served (present)...7-8-09. The home manager has been re-trained to insure that fire drills are held as prescribed by the standard schedule routinely. In addition, the QMRP will monitor monthly implementation and insure follow up for any failures to implement as prescribed or document properly...7-20-09	
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review, current job descriptions for all employees, for 4 out of 17 direct care staff. (Staff #2, #5, #6 and #7) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's	I 203	3509.3 Updated job descriptions will be reviewed and signed by...7-10-09. BRA will track annual updates via audits and insure timely follow up...7-30-09.	

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I 203	Continued From page 5 personnel files conducted on May 19, 2009 at approximately 1:30 PM, revealed the GHMRP failed to provide evidence that the facility discussed the contents of job description with staff. It should be noted that the presented records did not include a job description for Staff #2, #5, #6, and #7.	I 203		
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 interviews and record review, the facility failed to achieve compliance with state regulations pertaining to health (22DCMR 35, section 3509.6) for four (4) of sixteen (16) direct care staff and four (4) of fourteen (14) consultants. The finding includes: The State regulatory agency conducted a review of personnel records on June 19, 2009, at approximately 2:30 PM, at which time there was no evidence of current health certificates on file for four direct care staff (Staff #1, #3, #4, #5) and the four consultants (Consultant #1, #2, #3, #4). Interview with the Qualified Mental Retardation Professional on June 19, 2009, at approximately 3:00 PM confirmed the missing health certificates	I 206	3509.6 All staff and consultants cited will provide updated health certificates by...7-30-09. BRA tracks this concern proactively and notifies individuals of upcoming needs. In the future, failure to respond in a timely manner will be addressed via appropriate follow up actions...7-30-09.	

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I 206	Continued From page 6 were not available.	I 206		
I 221	3510.2 STAFF TRAINING Orientation training shall be the responsibility of each GHMRP and shall be documented in each employee ' s personnel folder. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all staff received their initial orientation training for three of sixteen direct care staff. (Staff #4, #8, and #9). The finding includes: Review of the personnel files on June 19, 2009, failed to provide orientation training for three direct care staff (Staff #3, #7 and #8).	I 221	3510.2 All staff members receive orientations prior to starting actual work but staff members with long histories with BRA do not have the current module. BRA will conduct orientations for individuals in that category by…7-20-09. All staff will have proper orientation documentation in place by…7-20-09.	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in CPR and first aid for seven (7) out of sixteen (16) direct care staff. (Staff #6, #9, #10, #11, #12 and #13) The finding includes:	I 227	3510.5 (d) CPR classes will be scheduled by 7-30-09. All staff out of compliance will be required to attend. BRA will track expiration dates and insure follow up training before such dates…7-20-09.	

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I 379	Continued From page 8 revealed that Resident #3 was transported to the hospital emergency room via the GHRMP transportation van for an elevated temperature. The client was diagnosed with hypertension and was prescribed Norvasc 10 mg. Further review of the incident report revealed that the incident was forwarded to the Department of Health (DOH) on March 27, 2009 nine (9) days later. Interview with the GHRMP Incident Management Coordinator (IMC) on June 18, 2009 at approximately 9:00 AM acknowledged that the incident report was not submitted timely to the governmental agency. 2. An incident report dated September 30, 2008, revealed Resident #5 was transported via 911 emergency services and admitted to the hospital for an elevated temperature. On October 1, 2008 at 2:05 PM, two (2) days later, the IMC called to report an incident that involved Resident #5. Reportedly on September 30, 2009, staff noticed that Resident #5's hands were shaking during snack time. The unusual incident report forwarded to DOH on October 7, 2008. Interview with the GHRMP Incident Management Coordinator (IMC) on June 18, 2009 at approximately 9:05 AM acknowledged that the incident report was not submitted timely to DOH.	I 379		
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:	I 401		

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BEHAVIOR RESEARCH ASSOCIATES	1034 BURNS ST., SE 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	PR (EACH CROSS-	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 227	Continued From page 7 Review of the training records on June 19, 2009 at approximately 11:00 AM, revealed the GHMRP failed to evidence documentation of staff training in cardiopulmonary resuscitation (CPR) and First Aid for staff #6, #9, #10, #11, #12 and #13.	I 227			
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all significant incidents were reported immediately to other officials according to District of Columbia Regulations (22 DCMR, Chapter 35, Section 3519.10) for two of six residents residing in the facility. (Resident #3 and #5) The findings include: On June 17, 2009, beginning at 3:07 PM, review of the GHMRP's unusual incident management system revealed the GHRMP failed to timely notify the governmental agency of the following incident(s): 1. An incident report dated March 19, 2009	I 379		3519.10 BRA will insure that incidents are submitted in a timely manner. The QMRP will track follow up by the IMC to insure that follow up is timely...7-10-09. Staff will be re-trained on the timely development of incident reports and timely notifications...7-20-09.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0023	A. BUILDING _____ B. WING _____	06/19/2009

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I 401	Continued From page 9 Based on interview and record review, the GHRMP failed to ensure that the health status was reviewed by the Registered Nurse (RN) staff on a quarterly or more frequent basis for two of the three residents included in the sample. (Residents #2 and #3) The findings include: 1. Review of Resident #1's medical record on June 17, 2009, at 11:20 AM, revealed an annual nursing assessment dated December 5, 2008. Further review of the medical records revealed there was no quarterly nursing assessment completed since December 2008. On June 18, 2009, at approximately 3:00 PM, interview with the GHMRP's supervisory Registered Nurse (RN) revealed that she was responsible for completing the quarterly nursing exams. The RN acknowledged that Resident #1's that the quarterly nursing had not been completed since December 2008. 2. Review of Resident #2's medical record on June 17, 2009, at 12:00 AM, revealed an annual nursing assessment dated December 3, 2008. Further review of the medical records revealed there was no quarterly nursing assessment completed since December 2008. On June 18, 2009, at approximately 3:05 PM, interview with the GHMRP's supervisory RN revealed that she was responsible for completing the quarterly nursing exams. The RN acknowledged that Resident #1's that the quarterly nursing had not been completed since December 2008.	I 401	3520.3 The unlabeled Protocream has been discarded and replaced. Nursing will audit the topical creams as well as the by mouth medications during their monthly audits and will address such concerns as they are found. In addition, nursing will support quarterly pharmacy reviews and insure the same follow up for issues found during that process...7-20-09. W440	