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

PRINTED: 12/19/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRA	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	W 000		
	A recertification survey was conducted from December 2, 2008 through December 4, 2008. The fundamental survey process was initiated however due to concerns in Client Behavior and Facility Practices, the survey was extended in that area. A random sample of three clients was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.		Received 12/31/08 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 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for the two of the three clients included in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure that informed	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda Graham — TITLE: 12/30/08 — (X6) DATE

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

Linda Graham

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W 124	Continued From page 1 consent was obtained from Client #1's mother prior to the administration of his psychotropic medications and prior to the implementation of two to one staffing support. a. Observation of the morning medication administration on December 2, 2008 at 7:20 PM revealed Client #2 was administered Vistaril 100 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. Review of Client #1's current physician orders dated December 2008 on December 2, 2008 at approximately 3:00 PM revealed that the client was also prescribed Prozac 80 mg to address his maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) at 3:10 PM indicated the aforementioned medications were used to address the client's behaviors. During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP that revealed Client #1 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on December 3, 2008, at 10:00 AM through review of Client #1's current psychological assessment. According to the assessment, Client #1 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight required to make decisions independently." Further interview with the QMRP during the	W 124	W124 BRA will insure that the behavior support plan for client #1 is revised to reflect the parameters of 2 to 1 support at the day program, up and down the stairs, in and out the van and in the community, etc. Client #1 does not need 2 to 1 support all waking hours but does need such support for specific situations and specific activities of daily living. The revised BSP dated 12/16/08 will reflect the specific parameters of 2 to 1 coverage and staff will be trained on the specific modifications...12-30-08. The legal guardian for client #1 will have the revised BSP reviewed with her as well as the associated psychotropic drug regimen by...12-30-08. Thereafter, any proposed changes in the BSP or psychotropic drug regimen will be discussed and reviewed with the legal guardian...12-30-08.	

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W 124	Continued From page 2 survey, revealed that the client had a very involved mother that was also his legal guardian. Record verification on December 3, 2008, at 11:30 AM revealed that although Client #1's mother had given informed consent for the psychotropic medications, the consent was signed on November 11, 2006 (nine months after the client was admitted to the facility). The client began receiving the aforementioned psychotropic medication in March 2006. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication. b. [Cross Refer W263] Observation on December 2, 2008 revealed Client #1 was receiving two to one staffing support. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 2, 2008 at 9:45 AM revealed Client #1 had one to one staff support 16 hours per day (4:00 PM - 8:00 AM) and two to one staff/client ratio at his day program (8:00 AM - 4:00 PM). During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP that revealed Client #1 had a legal guardian (mother). Continued interview with the QMRP and record review on December 3, 2008 failed to provide evidence that Client #1's mother was informed of the the use of two to one staffing support. 2. The facility failed to ensure that informed consent was obtained from Client #3 and/or her	W 124	In addition, the BRA Human Rights Committee will review the revised BSP, the staff coverage parameters outlined in the BSP and the psychotropic drug regimen currently taken by client #1.....12-30-08 A risks/benefits discussion will be conducted with the family member of client #3 concerning the psychotropic drug regimen. The family member currently signs for consent but the necessary paperwork has been sent to establish a legal guardian.....12-30-08. Thereafter, the QMRP will insure that the legal guardian is informed about any proposed changes in the psychotropic drug regimen prior to the implementation of such a change in non emergency situations.....12-30-08. The BRA HRC will also review the psychotropic drug regimen in its next committee meeting...12-30-08.	

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W 124	Continued From page 3 legal guardian prior to the administration of his psychotropic medications. Observation of the medication administration on December 2, 2008 at 7:05 PM revealed Client #3 was administered Haldol, Cogentin and Tofranil. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behavior. During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP and HM that revealed Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on December 3, 2008, at 11:30 PM through review of Client #3's psychological assessment dated July 2008. According to the assessment, Client #3 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight required to make decisions independently." The QMRP further revealed the client had active family involvement to assist him in decision making. Review of the client's medical record and additional interview with the QMRP on December 3, 2008, at 12:00 PM failed to provide evidence that Client #3's treatment needs, including the benefits and potential side effects associated with his medications, and the right to refuse treatment, had been explained to him and a legally authorized representative.	W 124		

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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, interview and record review, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for three of the three clients included in the sample. (Clients #1, #2, and #3) The findings include: 1. On December 2, 2008 at 7:45 PM, Client #2 was observed wearing high top boots and walking with a limp. Interview with the QMRP on December 3, 2008 indicated that the Physical Therapist (PT) recommended that the client wear high top "NIKE" boots. Record verification of the PT assessment on December 4, 2008 at 10:00 AM recommended that the client receive an evaluation by an orthotist for a left ankle brace to assist with dorsiflexion and inversion. Interview with the Registered Nurse at 12:30 PM revealed no knowledge of the PT's recommendation. Record verification of the medical record at 1:00 PM revealed no evidence of an orthotist evaluation. Interview with the PT at 2:30 PM revealed that the recommendation was still warranted at the time of the survey. There was no evidence that the QMRP scheduled or coordinated Client #2's orthotist appointment.	W 159	W159 The orthopedic consultation for client #2 was held on 12/17/08 and he was fitted for a left ankle brace at the Hanger Orthopedic Group to correct the dorsiflexion and inversion as recommended by [redacted] the Physical Therapist. The devise is described as a left sided ankle AFO to prevent planter flexion and inversion.....12-17-08. Follow up on all recommendations from the physical therapist are in progress..... 12-30-08. The left ankle brace has been ordered from the manufacturer and we are awaiting the delivery of the brace.....12-30-08. The NIKE high-top boots mentioned were obtained as recommended and have helped the problem for client #2.....12/30/08	

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W 159	Continued From page 5 2. The facility's QMRP failed to ensure that each employee had been provided with adequate training that enabled the employees to perform his or her duties effectively, efficiently and competently. [See W189] 3. The facility's QMRP failed to ensure each client received continuous active treatment services. [See W249] 4. The facility's QMRP failed to ensure that data was collected in the form and required frequency according to the Individual Program Plan. [See W252]	W 159	In the future, the RN will insure all such recommendations are implemented in a timely manner by reviewing the medical records on a monthly basis…12 30 -08. See also the responses for W189, W249 and W252.	
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 enabled the employee to perform his or her duties effectively, efficiently and competently. The finding includes: [See W193] The facility's staff failed to demonstrate the skills and techniques necessary to implement each client's Behavior Support Plan (BSP). Observations at Client #1's day program on December 2, 2008 at approximately 12:00 PM,	W 189		

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W 189	Continued From page 6 revealed two direct care staff were escorting (one staff on each side holding the client under his armpits) Client #1 to the nurse's station and to the dining room for lunch. After the client completed his lunch, the client was escorted to the bathroom, in the aforementioned manner. Interview with the staff that escorted Client #1 at the day program on December 2, 2008, (approximately 1:15 PM) verified they were his two to one support staff. NOTE: The staff were not observed or overheard asking the client to get up or go to the next assigned area. Review of Client #1's BSP dated March 8, 2008 on December 3, 2008 revealed that Client #1 had an Axis I diagnoses of Obsessive Compulsive Disorder and Pica. The client was prescribed Prozac to help manage his targeted behaviors (i.e. dropping to the floor, spitting, snatching food, pica, stripping, clothes tearing, property destruction, rectal digging). The BSP recommended the client receive one-on-one continuous staff monitoring, "all 24 hours of the day." Review of the facility's training record on December 4, 2008 at 10:00 AM revealed that the two to one staff support who were implementing Client #1's BSP at the day program on December 2, 2008, failed to provide evidence of training on Client #1's BSP.	W 189	W189 Staff will be retrained on the modified BSP with particular attention given to one-to-one supports parameters and 2 to 1 support parameters. The QMRP will ensure that each support staff demonstrate the skills and techniques necessary to properly implement each individuals BSP. The QMRP has ensured that all support staff who work with client #1 are trained on the behavioral support plan and strategies and techniques needed to administer proper interventions to use as outlined in the current behavioral support plan. The QMRP will also ensure that all support staff are trained on the rights of individuals and treating each individual with dignity ad respect..... ...12-30-08. All new staff will receive training on client #1's BSP and those of his peers during their initial, in-house orientation. In house orientations will occur within the first work week for all new employees...12-30-08.	
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 7 This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's Behavior Support Plan (BSP), for one of the three clients in the sample. (Client #1) The finding includes: Interview with the direct care staff on December 2, 2008 at 7:50 AM revealed that Client #1 received one to one support services. On December 2, 2008 at 8:10 AM, Client #1 was observed on the floor in the hallway entry. At 8:11 AM, two direct care staff were observed with their arms under the client's armpit and lifting the client to his feet. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 2, 2008 at 9:45 AM revealed that Client #1 had one to one staff support 16 hours per day (4:00 PM - 8:00 AM) and two to one staff/client ratio at his day program (8:00 AM - 4:00 PM). Observations at Client #1's day program on December 2, 2008 at approximately 12:50 PM, revealed two direct care staff were escorting (one staff on each side holding the client under his armpits) Client #1 to the nurse's station and to the dining room for lunch. After the client completed his lunch, the client was escorted to the bathroom, in the aforementioned manner. Interview with the staff that escorted Client #1 at the day program on December 2, 2008, (approximately 1:15 PM) verified they were his two to one support staff.	W 193	W193 Part of the modification process for the BSP of client #1 will involve insuring that the data collection system reflects the strategies outlined and the desired outcomes. This citation will be shared with the behavior specialist to insure that they understand the issues clearly. As mentioned in earlier responses, BRA will insure that the BSP is modified to clarity and that staff is trained on the modified program…12-30-08.	

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W 193	Continued From page 8 NOTE: The staff were not observed or overheard asking the client to get up or go to the next assigned area. Review of Client #1's BSP dated March 8, 2008 on December 3, 2008 revealed that Client #1 had an Axis I diagnoses of Obsessive Compulsive Disorder and Pica. The client was prescribed Prozac to help manage his targeted behaviors (i.e. dropping to the floor, spitting, snatching food, pica, stripping, clothes tearing, property destruction, rectal digging). The BSP recommended the client receive one-on-one continuous staff monitoring, "all 24 hours of the day." Further review of the BSP revealed the following procedures to address dropping to the floor as detailed below: a. Every time, the client drops to the floor staff should verbally prompt the client to get up and sit on a near by seat. If the client refuses, draw him to a seat with his favorite toy. b. If the client responds and makes an attempt, praise him immediately and encourage until he is actually seated. c. Place a manipulation items on the table. The client should be involved in active programming as much as possible. b. Whenever possible, activities should be alternated between the ones he enjoys and the ones he does not as much. c. When a task is presented to the client, staff should present choices. d. The client should be encouraged to be as	W 193		

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W 193	Continued From page 9 independent as he can while his one to one support staff continues to closely supervise him. e. Provide client with praise, attention and pats on his back when he is behaving appropriately. The data collection sheets were reviewed on December 3, 2008 at 10:00 AM. The data failed to evidence that the least restrictive techniques had been attempted prior to direct care staff restricting Client #1's movement during behavior episodes on December 2, 2008.	W 193		
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 provide continuous active treatment, for one of the three clients included in the sample. (Client #1) The findings include: On December 2, 2008 at 8:10 AM, Client #1 was observed on the floor in the hallway entry. At 8:11 AM, two direct care staff were observed with their arms under the client's armpit and lifting the client to his feet.	W 249	W249 See responses for W189 and W193	

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W 249	Continued From page 10 Observations at Client #1's day program on December 2, 2008 at approximately 12:50 PM, revealed two direct care staff escorting (one staff on each side holding the client under his armpits) Client #1 to the nurse's station and to the dining room for lunch. After the client completed his lunch, the client was escorted to the bathroom, in the aforementioned manner. On December 2, 2008 at 5:00 PM, Client #1 was observed falling on the dining room floor. The one to one support staff was observed placing his hands under the client's armpits from behind and lifting the client and assisting the client into his wheelchair. At 5:36 PM, Client #1 was observed sliding out of his wheelchair on the floor and then began crawling on the dining room floor. Two staff persons were observed attempting to get him off the floor. The House Manager was verbally encouraging the client to get up while the one to one support staff was bribing the client to get up, with fruit. On December 2, 2008 at 6:55 PM, Client #1 was observed on the floor. The medication nurse asked staff to assist Client #1 to the medication area. The client walked approximately three feet and was observed dropping to the floor. The one to one support staff and the HM attempted to pick the client up. After several unsuccessful attempts, the HM retrieved a bag of Chex cereal and apples. The HM was observed bribing the client with the edible items. Interview with the Qualified Mental Retardation Professional (QMRP) and Facility and Incident Management Coordinator (IMC) on December 4, 2008 at 9:45 AM revealed that Client #1 had a Behavior Support Plan (BSP) to address his	W 249		

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W 249	Continued From page 11 maladaptive behaviors of falling to the floor, food snatching, tearing down the blinds, etc. Review of Client #1's BSP dated March 8, 2008 on December 2, 2008 at 3:00 PM revealed the following maladaptive behaviors: dropping to the floor, food snatching, spitting, pica, stripping, clothes tearing, property destruction, and rectal digging. Further review of the BSP revealed the following procedures to address dropping to the floor as detailed below: a. Every time, the client drops to the floor staff should verbally prompt the client to get up and sit on a near by seat. If the client refuses, draw him to a seat with his favorite toy. b. If the client responds and makes an attempt, praise him immediately and encourage until he is actually seated. c. Place an manipulation items on the table. The client should be involved in active programming as much as possible. d. The client's one to one support staff should initiate the client interest in manipulating objects by manipulating the items first and talking about to the client. e. Staff should not tempt the client away from the floor by offering him edible bribes. f. If the client refused, staff should use disposable wet wipes to ensure that his hands are wiped and kept clean. There was no evidence that the facility implemented Client #1's BSP as instructed.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION	W 252		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 12 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 that data was collected in the form and required frequency, for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. [Cross-Ref W249] Observation of Client #1 on December 2, 2008 revealed the client exhibited targeted behaviors that were identified in his BSP. 2. On December 2, 2008 at 8:04 AM, Client #2 was observed playing with "Spin the top" toy. At 8:10 AM, the client was observed throwing the a "Spin the top" on the floor. At 8:15 AM, the client was observed pushing and throwing the "Spin the top" across the dining room table. At 5:40 PM, Client #2 used his head to push the surveyor in her abdomen area. At 5:20 PM, the client attempted to knock over the Christmas tree. Interview with the Qualified Mental Retardation Professional (QMRP) and Facility and Incident Management Coordinator (IMC) on December 4, 2008 at 9:45 AM revealed that Client #2 had a Behavior Support Plan (BSP) to address his behaviors of self injurious behaviors and aggression. Review of Client #2's BSP on December 4, 2008 at approximately 10:30 AM	W 252	W252 See Responses for W189 and W193 Staff will be retrained on data collection for the BSP of client #2 and client #3. The QMRP will review the data at minimum twice weekly to ensure ongoing consistency and follow-up as needed.....12-30-08. Staff retraining will occur on the individuals techniques and strategies as outlined in the BSP by the behavioral specialist.....12-30-08.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09/134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	4420 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 13 dated August 4, 2008 revealed the following maladaptive behaviors: self injurious behaviors, masturbation and agitation (stomping, hitting, knocking things off the table and pushing others, etc.) and non-compliance. Further review of the BSP required that all incidents of the targeted behaviors be documented on the behavioral data sheet. Review of the data sheet on December 4, 2008 at 10:45 AM failed to reflect the client's behavior on December 2, 2008. There was no evidence that the data had been collected in accordance with the BSP for the client, which was necessary for a functional assessment of the client's progress. 3. On December 2, 2008 at 5:25 PM, Client #3 was overheard screaming, "No, No, No." At 5:30 PM, Client #3 was overheard screaming, "No, No, No," at staff's request. Interview with the QMRP and IMC on December 2, 2008 at 9:45 AM revealed that Client #2 had a BSP to address his maladaptive behaviors of aggression and screaming. Review of Client #3's BSP on December 4, 2008 at approximately 2:00 PM dated July 16, 2008 revealed the following maladaptive behaviors: aggression and screaming (repeatedly). Further review of the BSP required that all incidents of the targeted behaviors be documented on the behavioral data sheet. Review of the data sheet on December 4, 2008 failed to reflect the client's behavior on December 2, 2008.	W 252		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	090134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRA	4600 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 263	Continued From page 14 consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients included in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure that written informed consent was obtained from Client #1's mother prior to the administration of his psychotropic medications and Behavior Support Plan (BSP). a. Observation of the morning medication administration on December 2, 2008 at 7:20 PM revealed Client #1 was administered Vistaril 100 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. Review of Client #1's current physician orders dated December 2008 on December 2, 2008 at approximately 3:00 PM revealed that the client was also prescribed Prozac 80 mg to address his maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) at 3:10 PM indicated the aforementioned medications were used to address the client's behaviors in conjunction with a BSP. Review of Client #1's BSP dated March 8, 2008	W 263	W263 See responses for W124	

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	09G134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	4600 6th BURROUGHS AVE, NE WASHINGTON, DC 20019

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W 263	Continued From page 15 on December 3, 2008 revealed that Client #1 had an Axis I diagnoses of Obsessive Compulsive Disorder and Pica. Continued review of the BSP revealed the client was to receive one-on-one continuous staff monitoring, "24 hours of the day." During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP that revealed Client #1 had a legal guardian (mother). Record verification on December 3, 2008, at 11:30 AM revealed Client #1's mother provided written informed consent for the BSP on November 11, 2008 (eight after the date of the BSP). At the time of the survey, the facility failed to provide evidence that written informed consent was obtained from the Client #1's mother prior to the implementation of the BSP. 2. Observation of the medication administration on December 2, 2008 at 7:05 PM, Client #3 was administered Haldol, Cogentin and Tofranil. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behavior. During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the Qualified Mental Retardation Professional (QMRP) and House Manager that revealed Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on December 3, 2008, at 11:30 PM through review of Client #3's psychological assessment dated July 2008. According to the assessment, Client #3 "is not able to make independent decisions concerning his residential	W 263		

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 12/04/2008
NAME OF PROVIDER OR SUPPLIER BRA		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 16th BURROUGHS AVE, NE WASHINGTON, DC 20019	

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W 263	Continued From page 16 or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight required to make decisions independently." The QMRP further revealed the client had active family involvement to assist him in decision making. Review of the client's medical record and additional interview with the QMRP on December 3, 2008, at 12:00 PM failed to provide evidence that Client #3's treatment needs, including the benefits and potential side effects associated with his medications, and the right to refuse treatment, had been explained to him and a legally authorized representative.	W 263		
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that techniques to address client behaviors were not used as a substitute for an active treatment program, for one of the three clients included in the sample. (Client #1) The findings includes: Interview with the direct care staff on December 2, 2008 at 7:50 AM revealed that Client #1 received one to one support services. On December 2, 2008 at 8:10 AM, Client #1 was	W 288		

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

PRINTED: 12/19/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G134	A. BUILDING _____ B. WING _____	12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRA	4939 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 288	Continued From page 17 observed on the floor in the hallway entry. At 8:11 AM, two direct care staff were observed with their arms under the client's armpit and lifting the client to his feet. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 2, 2008 at 9:45 AM revealed that Client #1 had one to one staff support 16 hours per day (4:00 PM - 8:00 AM) and two to one staff/client ratio at his day program (8:00 AM - 4:00 PM). Observations at Client #1's day program on December 2, 2008 at approximately 12:50 PM, revealed two direct care staff were escorting (one staff on each side holding the client under his armpits) Client #1 to the nurse's station and to the dining room for lunch. After the client completed his lunch, the client was escorted to the bathroom, in the aforementioned manner. Interview with the staff that escorted Client #1 at the day program on December 2, 2008, (approximately 1:15 PM) verified they were his two to one support staff. NOTE: The staff were not observed or overheard asking the client to get up or go to the next assigned area. Review of Client #1's BSP dated March 8, 2008 on December 3, 2008 revealed that Client #1 had an Axis I diagnoses of Obsessive Compulsive Disorder and Pica. The client was prescribed Prozac to help manage his targeted behaviors (i.e. dropping to the floor, spitting, snatching food, pica, stripping, clothes tearing, property destruction, rectal digging). The BSP recommended the client receive one-on-one continuous staff monitoring, "24 hours of the day." Continued review of the plan failed to indicate the	W 288	W288 See responses for W189 and W193	

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

PRINTED: 12/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRA	4620 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 288	Continued From page 18 use of two to one staffing support and further failed to document the specific techniques to be used by the two to one staff.	W 288		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure interventions to manage inappropriate client behavior were incorporated into the client's individual program plan, for one of the three clients in the sample. (Client #1) The finding includes: Interview with the direct care staff on December 2, 2008, at 7:50 AM revealed that Client #1 received one to one support services. On December 2, 2008 at 8:10 AM, Client #1 was observed on the floor in the hallway entry. At 8:11 AM, two direct care staff were observed with their arms under the client's armpit and lifting the client to his feet. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 2, 2008 at 9:45 AM revealed that Client #1 had one to one staff support 16 hours per day (4:00 PM - 8:00 AM) and two-to-one staff/client ratio at his day program (8:00 AM - 4:00 PM).	W 289	W289 See responses for W189 and W193	

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	09G134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	4229 NH BURROUGHS AVE, NE WASHINGTON, DC 20019

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W 289	Continued From page 19 During observations at Client #1's day program on December 2, 2008 at approximately 12:50 PM, two direct care staff were observed escorting (one staff on each side holding the client under his armpits) Client #1 to the nurse's station and to the dining room for lunch. After the client completed his lunch, the client was escorted to the bathroom, in the aforementioned manner. NOTE: The staff were not observed or overheard asking the client to get up or go to the next assigned area. Review of Client #1's Behavior Support Plan (BSP) dated March 8, 2008 on December 3, 2008 revealed that Client #1 had an Axis I diagnoses of Obsessive Compulsive Disorder and Pica. The client was prescribed Prozac to help manage his targeted behaviors (i.e. dropping to the floor, spitting, snatching food, pica, stripping, clothes tearing, property destruction, rectal digging). The BSP recommended the client receive one-on-one continuous staff monitoring, "24 hours of the day." Further review of the BSP, failed to identify the use of two to one staffing supports to assist the client at any time. At the time of the survey, the facility failed to provide evidence that the use of two to one staffing supports was incorporated into the BSP.	W 289		
W 296	483.450(d)(1)(i) PHYSICAL RESTRAINTS The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by:	W 296		

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	09G134		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRA	4628 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 295	Continued From page 20 Based on observation, interview and record review, the facility failed to provide evidence that the necessary use of physical restraints was incorporated into a client's Individual Program Plan (IPP), for one of the three clients included in the sample. (Client #1) The finding includes: There was no evidence that the facility ensured the use of Client #1's two to one staffing support was incorporated into his current Behavior Support Plan (BSP). [See W289]	W 295	W295 As mentioned in earlier responses, client #1 does not need 2 to 1 staff supports all waking hours but does need 2 to 1 supports for specific activities of daily living and situations. The BSP will be modified to reflect the proper parameters of 2 to 1 support and 1 to 1 support. Staff will subsequently be trained on both and all other modifications in the BSP for client #1 by…12-30-08.	
W 334	483.460(c)(3)(i) 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 by a direct physical examination. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that nursing assessments included direct physical examination. for one of the three clients included in the sample. (Client #2) The finding includes: Review of Client #2 medical record on December 4, 2008 at 11:00 AM revealed a nursing assessment dated August 6, 2008. The monthly nursing progress notes included lab results, medical appointments, and blood pressure readings. The monthly nursing progress notes failed to provide evidence that quarterly nursing assessments included direct physical	W 334	W334 The quarterly nursing review does include a "hands on" systems review by the nurse. The RN will modify her review format to insure that is clearly indicated as well as the results of the systems review…12-30-08.	

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 12/04/2008
NAME OF PROVIDER OR SUPPLIER B R A		STREET ADDRESS, CITY, STATE, ZIP CODE 4620 NH BURROUGHS AVE, NE WASHINGTON, DC 20019	

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W 334	Continued From page 21 examination and checks of all the body systems. Interview with the facility's Registered Nurse on December 4, 2008 at approximately 12:15 PM (RN) confirmed that the quarterly assessment had not been completed.	W 334		
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 a health status was reviewed by the nursing staff on a quarterly or more frequent basis, for one of the three clients in the sample. (Client #2) The finding includes: [Cross Refer W334] Review of Client #2's medical record on December 4, 2008 at approximately 11:00 AM revealed an annual nursing assessment dated August 6, 2008. Further review of the client's record revealed that there were no quarterly assessments in the record after the annual assessment. Interview with the Registered Nurse on December 4, 2008 at approximately 12:15 PM confirmed that the quarterly assessment had not been completed.	W 336		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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NAME OF PROVIDER OR SUPPLIER: BRA		STREET ADDRESS, CITY, STATE, ZIP CODE: 4520 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 440	Continued From page 22 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 each shift of personnel. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 4, 2008 at 1:40 PM revealed the facility had five shifts of direct care personnel. The shifts were weekdays 8 AM -4 PM, 4 PM - 12 PM, 12 PM - 8 AM and on weekends 8 AM - 8 PM and 8 PM - 8 AM. Review of the fire drill reports from February 2008 to November 2008 revealed that the last fire drill was conducted for the 8 AM-4 PM weekday shift on March 18, 2008. Further interview the HM 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 BRA will develop a universal, annual fire drill schedule for 2009 that will outline planned fire drills for each shift at least once a quarter and for all BRA homes. The schedule will be developed by…12-30-08. The QMRP will insure implementation of all planned fire drills via monthly reviews of the record. Any drill missed will be rescheduled for that particular shift within 7 days of its discovery…12-30-08.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	HFD83-668		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	4529 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 licensure survey was conducted from December 2, 2008 through December 4, 2008. The fundamental survey process was initiated however due to concerns in Client Behavior and Facility Practices, the survey was extended in that area. A random sample of three clients was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.	I 000		
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 interview and record review the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 4, 2008 at 1:40 PM revealed the facility had five shifts of direct care personnel. The shifts were weekdays 8 AM -4 PM, 4 PM - 12 PM, 12 PM - 8 AM and on weekends 8 AM - 8 PM and 8 PM - 8 AM. Review of the fire drill reports from February 2008 to November 2008 revealed that the last fire drill	I 135	3505.5 BRA will develop a 2009 universal fire drill schedule for all homes that outlines planned fire drills for all shifts at minimum once quarterly. QMRPs will monitor implementation and insure that any missed drills are made up within 7 days of discovery...12-31-08.	

Health Regulation Administration

Linda Graham — TITLE — 12/30/08 — (X6) DATE

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

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-006	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	STREET ADDRESS, CITY, STATE, ZIP CODE: 4920 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 135	Continued From page 1 was conducted for the 8 AM-4 PM weekday shift on March 18, 2008. Further interview the HM 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.	I 135		
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 record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files conducted on December 4, 2008 at approximately 11:00 AM, revealed the GHMRP failed to provide evidence that the facility discussed the contents of job description with staff. It should be noted that the present recorded did not include a job description for Staff #3.	I 203	3509.3 All staff members now have signed job descriptions in their folders that have been reviewed with them by their supervisor...12-31-08. BRA will insure routine compliance by tracking the dates for each person to insure that updates are done at minimum annually or as job descriptions are changed...12-31-08. Job descriptions are reviewed with new hires prior to their start date...12-31-08.	
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.	I 206		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NFD03-006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	STREET ADDRESS, CITY, STATE, ZIP CODE: 4539 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 2 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 (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on December 4, 2008, at which time there was no evidence of current health certificates on file for Staff #4, the behavior therapist, physical therapist and the occupational therapist.	I 206	3509.6 The staff member mentioned and the clinical consultants have been informed concerning their health certificate status. Each has been required to submit an updated certificate by...1-10-09. Failure to do so by staff will result in disciplinary action and withholding of checks for clinical consultants...1-10-09. BRA tracks compliance on a routine quarterly basis via record audits...1-10-09.	
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 (CPR), 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 all employees. The finding includes: Review of the training records on December 4, 2008 revealed the GHMRP failed to evidence documentation of staff training in cardiopulmonary resuscitation (CPR) for Staff #1 and #2 and First Aid for Staff #1 and #2.	I 227	3510.5 (d) All staff will have CPR and first aid training by...1-15-09. Staff routinely receives CPR/First aid training within the first month of employment with BRA...12-13-08.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD83-088	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: BRA	STREET ADDRESS, CITY, STATE, ZIP CODE: 4420 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 3	I 229		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specially areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies: This Statute is not met as evidenced by: Based on observation, staff interviews and record verification, the GHMRP staff failed to demonstrate competency in implementation the Behavior Support Plan, for one of the three residents in the sample. (Resident #1) The findings include: Interview with the direct care staff on December 2, 2008 at 7:50 AM revealed that Resident #1 received one to one support services. On December 2, 2008 at 8:10 AM, Resident #1 was observed on the floor in the hallway entry. At 8:11 AM, two direct care staff were observed with their arms under the resident's armpit and lifting the resident to his feet. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 2, 2008 at 9:45 AM revealed that Resident #1 had one to one staff support 16 hours per day (4:00 PM - 8:00 AM) and two to one staff/resident ratio at his day program (8:00 AM - 4:00 PM). Observations at Resident #1's day program on December 2, 2008 at approximately 12:50 PM, revealed two direct care staff were escorting (one staff on each side holding the resident under his armpits) Resident #1 to the nurse's station and to	I 229	3510.5 (f) See responses W189 and W193 3521.3 See: responses for 3510.5 (f) above.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD63-[illegible]	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	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 4 the dining room for lunch. After the resident completed his lunch, the client was escorted to the bathroom, in the aforementioned manner. Interview with the staff that escorted Resident #1 at the day program on December 2, 2008, (approximately 1:15 PM) verified they were his two to one support staff. NOTE: The staff were not observed or overheard asking the resident to get up or go to the next assigned area. Review of Resident #1's BSP dated March 8, 2008 on December 3, 2008 revealed that Resident #1 had an Axis I diagnoses of Obsessive Compulsive Disorder and Pica. The residentwas prescribed Prozac to help manage his targeted behaviors (i.e. dropping to the floor, spitting, snatching food, pica, stripping, clothes tearing, property destruction, rectal digging). The BSP recommended the client receive one-on-one continuous staff monitoring, "all 24 hours of the day." Further review of the BSP revealed the following procedures to address dropping to the floor as detailed below: a. Every time, the resident drops to the floor staff should verbally prompt the client to get up and sit on a near by seat. If the resident refuses, draw him to a seat with his favorite toy. b. If the resident responds and makes an attempt, praise him immediately and encourage until he is actually seated. c. Place a manipulation items on the table. The resident should be involved in active programming as much as possible. b. Whenever possible, activities should be	I 229		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-006	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	STREET ADDRESS, CITY, STATE, ZIP CODE: 4620 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	I 229		
	alternated between the ones he enjoys and the ones he does not as much. c. When a task is presented to the resident, staff should present choices. d. The resident should be encouraged to be as independent as he can while his one to one support staff continues to closely supervise him. e. Provide resident with praise, attention and pats on his back when he is behaving appropriately. The data collection sheets were reviewed on December 3, 2008 at 10:00 AM. The data failed to evidence that the least restrictive techniques had been attempted prior to direct care staff restricting Resident #1's movement during behavior episodes on December 2, 2008.			
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide training and assistance to residents in accordance with the their Individual Habilitation Plans for one of the three residents included in the sample. (Resident #1) The findings include: On December 2, 2008 at 8:10 AM, Resident #1 was observed on the floor in the hallway entry. At 8:11 AM, two direct care staff were observed with	I 422		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD09-888	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	STREET ADDRESS, CITY, STATE, ZIP CODE: 4600 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 422	Continued From page 6 their arms under the resident's armpit and lifting the client to his feet. Observations at Resident #1's day program on December 2, 2008 at approximately 12:50 PM, revealed two direct care staff escorting (one staff on each side holding the client under his armpits) Resident #1 to the nurse's station and to the dining room for lunch. After the resident completed his lunch, the resident was escorted to the bathroom, in the aforementioned manner. On December 2, 2008 at 5:00 PM, Resident #1 was observed falling on the dining room floor. The one to one support staff was observed placing his hands under the resident's armpits from behind and lifting the client and assisting the resident into his wheelchair. At 5:36 PM, Client #1 was observed sliding out of his wheelchair on the floor and then began crawling on the dining room floor. Two staff persons were observed attempting to get him off the floor. The House Manager was verbally encouraging the resident to get up while the one to one support staff was bribing the resident to get up, with fruit. On December 2, 2008 at 6:55 PM, Resident #1 was observed on the floor. The medication nurse asked staff to assist Resident #1 to the medication area. The client walked approximately three feet and was observed dropping to the floor. The one-to-one support staff and the HM attempted to pick the resident up. After several unsuccessful attempts, the HM retrieved a bag of Chex cereal and apples. The HM was observed bribing the client with the edible items. Interview with the Qualified Mental Retardation Professional (QMRP) and Facility and Incident	I 422		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	HFD03-[illegible]		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRA	4620 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 422	Continued From page 7 Management Coordinator (IMC) on December 4, 2008 at 9:45 AM revealed that Resident #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors of falling to the floor, food snatching, tearing down the blinds, etc. Review of Resident #1's BSP dated March 8, 2008 on December 2, 2008 at 3:00 PM revealed the following maladaptive behaviors: dropping to the floor, food snatching, spitting, pica, stripping, clothes tearing, property destruction, and rectal digging. Further review of the BSP revealed the following procedures to address dropping to the floor as detailed below: a. Every time, the resident drops to the floor staff should verbally prompt the resident to get up and sit on a near by seat. If the resident refuses, draw him to a seat with his favorite toy. b. If the resident responds and makes an attempt, praise him immediately and encourage until he is actually seated. c. Place an manipulation items on the table. The resident should be involved in active programming as much as possible. d. The resident's one to one support staff should initiate the resident interest in manipulating objects by manipulating the items first and talking about to the client. e. Staff should not tempt the resident away from the floor by offering him edible bribes. f. If the resident refused, staff should use disposable wet wipes to ensure that his hands are wiped and kept clean. There was no evidence that the facility	I 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HF083-[illegible]		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	4625 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 422	Continued From page 8 implemented Resident #1's BSP as instructed.	I 422		
I 436	3521.7(h) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (h) Interpersonal and social skills (including sharing, courtesy, cooperation, responsibility and age-appropriate and culturally normative social behaviors and relationships involving peers of the same and different sex, younger and older persons and person in authority); This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure training for social and adaptive behaviors were measurable for one of the two residents in the sample. (Resident #1) The finding includes: 1. [Cross-Ref W249] Observation of Resident #1 on December 2, 2008 revealed the resident exhibited targeted behaviors that were identified in his BSP.	I 436	3521.7 (h) See responses W252 #2	
	2. On December 2, 2008 at 8:04 AM, Resident #2 was observed playing with "Spin the top" toy. At 8:10 AM, the client was observed throwing the a "Spin-the-top" on the floor. At 8:15 AM, the resident was observed pushing and throwing the "Spin the top" across the dining room table. At 5:40 PM, Resident#2 used his head to push the surveyor in her abdomen area. At 5:20 PM, the resident attempted to knock over the Christmas tree.			

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 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	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 438	Continued From page 9 Interview with the Qualified Mental Retardation Professional (QMRP) and Facility and Incident Management Coordinator (IMC) on December 4, 2008 at 9:45 AM revealed that Resident #2 had a Behavior Support Plan (BSP) to address his behaviors of self injurious behaviors and aggression. Review of Resident #2's BSP on December 4, 2008 at approximately 10:30 AM dated August 4, 2008 revealed the following maladaptive behaviors: self injurious behaviors, masturbation and agitation (stomping, hitting, knocking things off the table and pushing others, etc.) and non-compliance. Further review of the BSP required that all incidents of the targeted behaviors be documented on the behavioral data sheet. Review of the data sheet on December 4, 2008 at 10:45 AM failed to reflect the resident's behavior on December 2, 2008. There was no evidence that the data had been collected in accordance with the BSP for the resident, which was necessary for a functional assessment of the resident's progress. 3. On December 2, 2008 at 5:25 PM, Resident #3 was overheard screaming, "No, No, No." At 5:30 PM, Resident #3 was overheard screaming, "No, No, No," at staff's request.	I 438		
	Interview with the QMRP and IMC on December 2, 2008 at 9:45 AM revealed that Resident #2 had a BSP to address his maladaptive behaviors of aggression and screaming. Review of Resident #3's BSP on December 4, 2008 at approximately 2:00 PM dated July 16, 2008 revealed the following maladaptive behaviors: aggression and screaming (repeatedly). Further review of the BSP required that all incidents of the targeted behaviors be documented on the behavioral data sheet. Review of the data sheet on December 4,			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-666		12/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B R A	4620 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 438	Continued From page 10 2006 failed to reflect the resident's behavior on December 2, 2006.	I 438		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to ensure clients were not subjected to verbal, physical and psychological abuse and mistreatment, for three of the three residents that resided in the facility. (Residents #1, #2 and #3) The findings include: [Cross-Ref W124 and W263] 1. The facility failed to ensure that informed consent was obtained from Resident #1's mother prior to the administration of his psychotropic medications and prior to the implementation of two to one staffing support. a. Observation of the morning medication administration on December 2, 2006 at 7:20 PM revealed Resident #2 was administered Vistaril 100 mg. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors. Review of Resident #1's current physician orders dated December 2006 on December 2, 2006 at approximately 3:00 PM revealed that the resident	I 500	3523.1 See W124 response in the entirety	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-[illegible]	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	STREET ADDRESS, CITY, STATE, ZIP CODE: 4420 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 500	Continued From page 11 was also prescribed Prozac 80 mg to address his maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) at 3:10 PM indicated the aforementioned medications were used to address the resident's behaviors. During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP that revealed Resident #1 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on December 3, 2008, at 10:00 AM through review of Resident #1's current psychological assessment. According to the assessment, Resident #1 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight required to make decisions independently." Further interview with the QMRP during the survey, revealed that the resident had a very involved mother that was also his legal guardian. Record verification on December 3, 2008, at 11:30 AM revealed that although Resident #1's mother had given informed consent for the psychotropic medications, the consent was signed on November 11, 2008 (nine months after the resident was admitted to the facility). The resident began receiving the aforementioned psychotropic medication in March 2008. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to the	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD63-668	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: BRA	STREET ADDRESS, CITY, STATE, ZIP CODE: 4620 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 500	Continued From page 12 administration of the psychotropic medication. b. [Cross Refer W263] Observation on December 2, 2008 revealed Client #1 was receiving two to one staffing support. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on December 2, 2008 at 9:45 AM revealed Resident #1 had one to one staff support 16 hours per day (4:00 PM - 8:00 AM) and two to one staff/resident ratio at his day program (8:00 AM - 4:00 PM). During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP that revealed Client #1 had a legal guardian (mother). Continued interview with the QMRP and record review on December 3, 2008 failed to provide evidence that Resident #1's mother was informed of the the use of two to one staffing support. 2. The facility failed to ensure that informed consent was obtained from Resident #3 and/or her legal guardian prior to the administration of his psychotropic medications. Observation of the medication administration on December 2, 2008 at 7:05 PM revealed Resident #3 was administered Haldol, Cogentin and Tofranil. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the resident's behavior. During the entrance conference on December 2, 2008 at 9:45 AM, an interview was conducted with the QMRP and HM that revealed Resident #3 did not have the capacity to give informed consent for the use of medications and	I 500		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD09-008	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 12/04/2008
NAME OF PROVIDER OR SUPPLIER: B R A	STREET ADDRESS, CITY, STATE, ZIP CODE: 4020 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 500	Continued From page 13 habilitation services. The QMRP's statement was verified on December 3, 2008, at 11:30 PM through review of Resident #3's psychological assessment dated July 2008. According to the assessment, Resident #3 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent. He lacks the judgment and insight required to make decisions independently." The QMRP further revealed the resident had active family involvement to assist him in decision making. Review of the client's medical record and additional interview with the QMRP on December 3, 2008, at 12:00 PM failed to provide evidence that Resident #3's treatment needs, including the benefits and potential side effects associated with his medications, and the right to refuse treatment, had been explained to him and a legally authorized representative.	I 500		