

Health Regulation & Licensing 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 03/27/2013 |
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| I 000 | INITIAL COMMENTS A licensure survey was conducted from March 25, 2013 through March 27, 2013. A sample of three residents was selected from a population of five males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.] | I 000 | | | |
| I 180 | 3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure that the qualified intellectual disabilities professional (QIDP) incorporated day program data into each resident's IPP; advise direct support staff on how to prepare meal with altered texture consistency in accordance with each resident's plan; and develop a plan for release from wrist guards, for one of three residents in the sample. (Resident #3) The findings include: | I 180 | | | |

Health Regulation & Licensing Administration

Cassie K. Hurd

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

TITLE

Administrator

(X6) DATE

4/29/13

Health Regulation & Licensing 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 03/27/2013 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| I 180 | <p>Continued From page 1</p> <p>1. The QIDP (Staff #1) failed to incorporate behavior data into the individual program plan, as follows:</p> <p>On March 26, 2013, commencing at 10:35 a.m., Resident #3 was observed at his day program. At the onset of the observation, Resident #3 was engaged in a ball tossing activity. In concurrent interview with the classroom instructor (DPS #1), he was asked if Resident #3 had any formal training objectives. The instructor mentioned Resident #3 also participated in recreational activities, noting Resident #3 liked to "spin" objects. DPS #1 also commented Resident #3 participated in music. At 10:40 a.m., Resident #3 was escorted out of the classroom to a restroom by his one-to-one direct support staff (Staff #10).</p> <p>Record review of Resident #3's day program plan on March 26, 2013, commencing at 10:45 a.m., revealed training objectives had been established at an Individual Program Plan (IPP) meeting conducted on August 10, 2012. There was also a provision for the collection of behavior relevant to the target behaviors of self-injury, agitation, physical aggression and inappropriate sexual behavior. Monthly data computations for the respective objectives along with frequency tabulations for target behaviors were computed and there also were quarterly reviews. When Resident #3's Case Manager (CM, DPS #2) was asked who received a copy of this information, she explained she sent all her reports to the facility's QIDP.</p> <p>In a follow-up interview with the QIDP on March 26, 2013 at 2:30 p.m., she was asked if she incorporated the behavior data from Resident #3's day program into the IPP. She acknowledged she received the information, but</p> | I 180 | <p>3508.1</p> <ol style="list-style-type: none"> The QIDP will ensure that behavior data collected at the day program is incorporated into the data-based review of targeted behaviors in the QIDP summaries developed quarterly and periodically...5-1-13 <p>Additionally, the QIDP will ensure that psychology receives the day program behavior data prior to monthly psychotropic medication reviews so that a 24/7 performance criteria is used to examine the progress made and make informed decisions as a team...5-1-13</p> <ol style="list-style-type: none"> The RN will retain all staff including the QIDP on the special diet considerations for Client #3 and all of the individuals that have special diets...5-7-13 <p>The nutritionist will provide follow up training by...5-20-13</p> <p>The training provided by the nutritionist will address the food texture issue and provide staff with specific training and practical definitions (with examples) as to what constitutes each prescribed texture. The QIDP will request handouts that staff can refer back to for guidance after the training has been completed...5-20-13</p> <p>Once appropriately trained by the RN and the nutritionist, the QIDP and Home Manager will conduct routine observations of meals at minimum weekly to ensure that meals are served in the proper texture for each person supported...5-20-13.</p> <ol style="list-style-type: none"> The PCP will be contacted by the RN and QIDP to discuss the wrist guard recommendation for Client #3 (from dermatology); if the PCP agrees, a physician's order will be added prescribing the use of the wrist guards...5-1-13 | |

Health Regulation & Licensing 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 03/27/2013 |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|----------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| I 180 | <p>Continued From page 2</p> <p>did nothing with the data since the program was a separate outside service.</p> <p>2. The QIDP offered improper meal texture instructions to direct support staff, as follows:</p> <p>On March 26, 2013, commencing at 7:05 a.m., Resident #3's one-to-one staff (Staff #10) tried to encourage Resident #3 to eat, but he refused. The texture of the meal was noted to be finely chopped and Staff #10 stated she would try to encourage the resident to eat the meal later. At 8:05 a.m., the QIDP entered the kitchen as Staff #10 was about to reheat Resident #3's breakfast. The QIDP instructed her to blend the food to a pureed texture after observing that the food was finely chopped.</p> <p>At 8:40 a.m., the house manager (HM, Staff #2) was observed feeding Resident #3 in his bedroom. It was the last spoonful, therefore the HM was asked to describe the texture of the meal that she had presented. She stated that Resident #3 was required to receive a finely chopped diet consistency, and she had ensured he received the proper consistency, not the pureed blend as suggested by the QIDP.</p> <p>Record review for Resident #3 on March 26, 2013, commencing at 2:00 p.m., revealed a nutrition assessment dated May 3, 2012, verifying that Resident #3 should receive a regular diet with double portions in a finely chopped texture consistency.</p> <p>3. The QIDP failed to develop a monitoring plan for the use of, and reduction of dependency on, wrist guards, as follows:</p> <p>On March 25, 2013, at 6:05 p.m., Resident #3</p> | I 180 | <p>Once this is done, the issue will be presented to the BRA Human Rights Committee for review and approval. If the committee does not approve the use of the wrist guards, they will be discontinued. If they are approved, the QIDP will ensure that psychology addresses the use of the wrist guards in the BSP and sets parameters for the reduction of the use of the wrist guards...5-20-13</p> <p>If this results in a modification in the BSP, the modified BSP will be presented to the RCRC committee of DDS for review and approval...5-30-13.</p> <p>Psychology will also review the existing behavior support strategies to ensure effective strategies are in place to reduce the self injurious biting behavior and will modify the existing strategies or add new strategies if that is deemed necessary...5-20-13</p> <p>If at any point during the process, the use of the wrist guards is disapproved by DDS, the use will be immediately discontinued...5-30-13</p> <p>It should be noted that the use of the wrist guards has helped to greatly reduce the damage done to Client #3's wrists and arms based on the self injurious biting behavior.</p> | | |

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|

| | | | | |
|-------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|
| I-180 | <p>Continued From page 3</p> <p>was observed at dinner. Resident #3 had splints on both of his wrists as he ate. Concurrent interview with his one-on-one direct support staff (Staff #13) at the time revealed the splints were used for "contractures."</p> <p>Record review for Resident #3 on March 26, 2013, commencing at 2:00 p.m., revealed a dermatology consult dated March 13, 2012. It documented "Lichen Simplex Chronicus of both dorsal hands - dry, rough, thickened from repetitive rubbing, scratching and biting. Recommendations - keep wrist guards in place as they help decrease his hand biting/rubbing."</p> <p>Additional documentation related to Resident #3's biting behavior was evident in the monthly "Health Risk Management Care Plans" completed by nursing personnel from August 2012 through February 2013. In each month, it stated "Encourage wrist guards to reduce hand biting."</p> <p>Concurrent review of the behavior support plan (BSP) for Resident #3 revealed a BSP with an effective date of August 9, 2012, revealed a "Behavior Support History" that included "[Resident #3's name] has historically had an Axis 1 diagnosis of Obsessive Compulsive Disorder and Intermittent Explosive Disorder. He has received behavior support for several years for hand and wrist biting. Calluses have resulted on the back of his hand from these incidents and have led to consultations with dermatology. He was prescribed the use of wrist guards."</p> <p>Per review of the most recent physician order sheets in Resident #3's record, dated February 26, 2013, there was no order specifically written for the wrist guards.</p> | I 180 | | |
|-------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|

I-180 Continued From page 4

In a follow-up interview with the QIDP, on March 26, 2013, at 3:25 p.m., to ascertain if there were any current physician orders for wrist guards, the QIDP verified there were none after conducting her own review. When the QIDP was asked how the wrist guards were to be used, given the comments provided by the dermatologist and monitored by nursing as being necessary due to biting behavior, she explained that since restraints were not used at the facility, this could not be part of the resident's plan. The QIDP inferred that the Department on Disability Services (DDS) would not approve a plan if restraints were suggested. When she was asked if there was a plan outlining the application, release, the documentation necessary, as well as a plan for reduction of the use of wrist guards, the QIDP verified there were no such provisions in place.

I 180

I-206 3509.6 PERSONNEL POLICIES

Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.

This Statute is not met as evidenced by:
Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all employees and health care professionals had current health certificates on file, for 2 of 7 nurses.

I 206

3509.6

BRA has requested the needed health certificates from staff 19 and 20 and will obtain the documents by...5-10-13
BRA will track this consideration proactively for both staff and clinical consultants and provide advance notification of the need to provide an updated document...5-1-13
Effective immediately, staff that fail to provide the updated information by the due date will be removed from the schedule until the document is received and consultants will have their most current pay check held until compliance is reached...5-1-13

The findings include:

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------|

| | |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| I 206 | Continued From page 5 On March 27, 2013, beginning at approximately 4:30 p.m., review of the personnel records for all employees, including licensed professionals revealed the following: 1. There was no evidence of a current physician's health inventory/certificate for one of three registered nurses (Staff #19). 2. There was no evidence of a complete physician's health inventory/certificate for one of four licensed practical nurses (Staff #20). Interview with the house manager (Staff #2) on March 27, 2013, at approximately 5:00 p.m., revealed she would retrieve the aforementioned documents. | I 206 | | |
| I 226 | 3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all staff received effective training on infection control, for two of nine direct support staff. (Staff #13 and #17) The findings include: 1. On March 25, 2013, Resident #3 and his assigned one-to-one direct support staff (Staff #13) were observed in the facility, beginning at | I 226 | 3510.5(C) Staff will be retrained on infection control by...5-7-13 Additionally, the QIDP will discuss the issue of Client #3 licking the ball or balls with the licensed psychologist and ask the psychologist to assist in developing strategies that staff will be trained to use that allow Client #3 to enjoy playing with balls while preventing the licking behavior. The psychologist will be contacted and the strategies will be developed by...5-10-13 Staff will be trained and the strategies will be implemented by...5-15-13 The QIDP and Home Manager will monitor implementation of the prescribed strategies (once developed and staff is trained) during routine observations of active treatment weekly...6-1-13 | |

| | | | |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|
| 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
| 1.226 | <p>Continued From page 6</p> <p>6:00 p.m. Prior to the dinner meal being served, Resident #3 was engaged in a ball toss activity in which he would touch the ball, roll the ball on the floor and sometimes place the ball to his face. Additionally, Resident #3 was offered a popper top spinning toy that he would sometimes lick. During these observations, Staff #13 did not intervene in any manner with Resident #3 to get him to keep the items away from his face, lips, or tongue. Prior to the meal being served, Resident #3 was not encouraged to wash his hands.</p> <p>2. On March 26, 2013, beginning at 6:55 a.m., observations of Resident #3 and his assigned one-to-one direct support staff (Staff #17) revealed the following:</p> <p>6:55 a.m. - Resident #3 was observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>7:09 a.m. - Resident #3 was observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>7:25 a.m. - Resident #3 was observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>8:00 a.m. - Resident #3 was again observed licking a toy that was on the living room carpet. No staff redirection was provided.</p> <p>In an interview with the qualified intellectual disabilities professional (QIDP, Staff #1) on March 26, 2013, at 4:35 p.m., the QIDP was asked if facility staff had been trained in matters of infection control. The QIDP stated that the issue of cleaning training materials had been discussed with all staff on a routine basis. [Note:</p> | 1.226 | | |

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| I 226 | Continued From page 7 On March 27, 2013, review of staff in-service training records, beginning at 12:30 p.m., failed to show evidence of training on infection control. The QIDP and the house manager (Staff #2) looked for documentation of said training but at approximately 1:15 p.m., they acknowledged that there were no records available for verification.] | I 226 | | |
| I 229 | 3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that staff received effective training on accurate documentation of seizures, for one of three residents in the sample. (Resident #2) The finding includes: On March 25, 2013, at approximately 9:00 a.m., Resident #2 was observed wearing a soft helmet while ambulating from the living room to the dining room. He was observed wearing the helmet again while ambulating later on that day, at approximately 4:40 p.m. His day shift one-to-one direct support staff (Staff #11) stated Resident #2 must wear the helmet while ambulating for safety, due to risk of seizures. At 6:52 p.m., Resident #2 was observed being administered Tegretol 300 milligram (mg), Keppra | I 229 | 3510.5 (f) Staff will receive updated training on completing the seizure report documents properly. The RN will conduct the training by...5-7-11 The RN and QIDP will review seizure documentation weekly as needed to ensure that all elements of the form are properly completed. The RN or QIDP will provide follow up training if issues are discovered during the audit process...5-1-13 | |

Health Regulation & Licensing 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 03/27/2013 |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| 1229 | <p>Continued From page 8</p> <p>500 mg and Lyrica 100 mg by the evening nurse (Staff #7). The nurse confirmed that the three aforementioned medications were prescribed for seizure management.</p> <p>On March 26, 2013, at 7:53 a.m., Resident #2's nighttime one-to-one staff (Staff #12) was overheard informing the qualified intellectual disabilities professional (Staff #1) that the resident had experienced a seizure overnight. At approximately 8:20 a.m., Resident # 2 was observed to be lying on the floor. His body was stiffened, jerking, his eyes were staring straight forward, and some drool was observed coming out the corner of his mouth. [Note: his head was turned to the side and cushioned by Staff #11, for safety].</p> <p>On March 26, 2013, at approximately 4:35 p.m., review of the seizure report form that was completed by Staff #12 for the seizure witnessed at approximately 8:20 a.m. earlier that day revealed that he did not document that Resident #2's eyes had been staring or that he had drooled (both are signs/symptoms listed on the report forms and for which staff are expected to check-off if observed). In addition, Staff #12 had failed to document whether or not the resident was sent to the emergency room (ER) that morning.</p> <p>Continued review of seizure report forms revealed a total of 20 seizure incidents had been reported during the period August 8, 2012 - March 26, 2013. Of those 20 reports, staff failed to document whether or not Resident #2 had been sent to the ER on 5 out of 20 (1/4) of the forms.</p> <p>On March 27, 2013, at 1:18 p.m., review of the</p> | 1229 | | | |

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| I 229 | Continued From page 9 facility's staff in-service training records revealed that on November 5, 2012, a registered nurse had presented training on seizure management. A signature sheet documented the attendance of Staff #12 for the training. Review of Resident #2's seizure report forms, however, revealed that the training had not been effective. | I 229 | | |
| I 426 | <p>3521.5(c) HABILITATION AND TRAINING</p> <p>Each GHMRP shall make modifications to the resident 's program at least every six (6) months or when the client:</p> <p>(c) Is failing to progress toward identified objectives after reasonable efforts have been made;</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure its outside day program accurately documented progress during quarterly reviews and revised one training objective when lack of progress was noted for one of three clients in the sample. (Resident #3)</p> <p>The findings include:</p> <p>1. The facility failed to ensure its outside day program revised one training objective when lack of progress was noted as follows:</p> <p>On March 26, 2013, commencing at 10:35 a.m., review of objective 3 revealed, "Given physical assistance as needed, [Resident #3] will operate a CD player on 80% of opportunities provided for 6 consecutive months within one year" had been established at the August 2012 planning meeting. Data was entered in the record since establishment and was reflected as: September -</p> | I 426 | <p>3521.5 (C)</p> <p>The QIDP will meet with the day program of Client #3 to ensure that the corrections necessary for the three IPP objectives are made and the programs are properly implemented thereafter... 5-10-13</p> <p>The QIDP will review the data for all measurable objectives run at the day program during monthly visits to ensure that the data is an accurate reflection of progress made or the lack thereof and that appropriate adjustments are made based on the (data-based) results... beginning 5-1-13</p> <p>The QIDP will also review the quarterly and other periodic reports submitted by the day program for the same considerations and provide feedback as needed... beginning 5/13</p> | |

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
| 1426 | <p>Continued From page 10</p> <p>0%; October - 0%; November - 0%; December - 0%; January 10%.</p> <p>In an interview with the CM on March 26, 2013, commencing at 11:33 a.m., she was asked if any revision to the IPP had been made since Resident #3 had not made any progress in this training objective for five consecutive months. The CM commented the team only gets together two times per year to discuss progress or lack of progress and she would make a change in the objective at Resident #3's next scheduled meeting.</p> <p>2. The facility failed to ensure its outside day program accurately documented Resident #3's progress as follows:</p> <p>On March 26, 2013, commencing at 10:35 a.m., Resident #3 was observed at his day program. At the onset of the observation, Resident #3 was engaged in a ball tossing activity. In concurrent interview with Resident #3's classroom instructor (DPS #1), he was asked if Resident #3 had any formal training objectives. The instructor mentioned Resident #3 also participated in recreational activities, noting Resident #3 liked to "spin" objects. DPS #1 also commented Resident #3 participated in music. At 10:40 a.m., Resident #3 was escorted out of the classroom to a restroom by his one-to-one direct support staff. (Staff #10)</p> <p>Review of Resident #3's day program plan on March 26, 2013, commencing at 10:45 a.m., revealed training objectives had been established at an Individual Program Plan (IPP) meeting conducted on August 10, 2012. The record also contained evidence of monthly data computations for the respective objectives along with frequency</p> | 1426 | | |

Health Regulation & Licensing 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 03/27/2013 |
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| I 426 | Continued From page 11 tabulations for target behaviors. There also were quarterly reviews. Objective 1 - "Given unlimited verbal prompts, [Resident #3] will choose the activities he wants to participate in (ball-toss, bowling, spinning wheel) daily 50% of the time for six consecutive months within one year - 8/2012 to 8/2013" had been established. For the quarterly review covering the months of November 2012, December 2012 and January 2013, data was entered as: November - 88%; December -74%; January 50%. A case manager (CM) comment was documented, "Criterion not achieved at 76%." By data entry, the objective had actually been met in the quarter, since the criterion for success had been established at 50%. Objective 2 - "Given no more than 3 verbal prompts, [Resident #3] will choose a partner to dance with during music therapy, 2 times weekly on 80% of opportunities provided for 6 consecutive months within one year" had been established. For the quarterly review covering the months of November 2012, December 2012 and January 2013, data was entered as: November - 25%; December -0%; January 0%. A CM comment was documented, "Criterion not achieved at 100%." Though the objective had not been met as specified, the percentage for success that was reflected was inaccurate. Objective 3 - "Given physical assistance as needed, [Resident #3] will operate a CD player on 80% of opportunities provided for 6 consecutive months within one year" had been established. For the quarterly review covering the months of November 2012, December 2012 and January 2013, data was entered as: November - 0%; December -0%; January 0%. A CM comment was | I 426 | | |

| 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 03/27/2013 |
|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| I 426 | Continued From page 12 documented, "Criterion not achieved at 36%," Though the objective had not been met, the percentage reflected for success was also in error. In an interview with Client #3's day program CM (DPS #2) on March 27, 2013, at 11:33 a.m., she was asked to verify the data computations and comments that had been documented in Resident #3's record. The CM stated she was new to the program and admitted all three objectives had errors in calculations and the corresponding comments. The CM also stated she would make the corrections. | I 426 | | |
| I 436 | 3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the group home for individuals with intellectual disabilities (GHIID) failed to afford each resident the opportunity to participate with self medication to the extent of his ability, for one of five residents residing in the facility. (Resident #4) The finding includes: On March 25, 2013, at approximately 5:00 p.m., Resident #4 ate his snack independently with a regular utensil and cup then cleared the table. At | I 436 | 3521.7 (f) A task program surrounding times that medications are passed will be implemented for Client #4 that reflects his existing strengths and capabilities and his potential for accomplishing the tasks...5-10-13 The program will be implemented beginning...5-15-13 The RN has reviewed the self medication assessments for each person supported and the self medication programs to determine if there are any improvements or new individuals that may be capable of participating. All of the individuals currently at BRA remain able to only participate in the "TASKS" surrounding self-medication, not the clinical/cognitive process of self-medication. The assessments will be completed in writing, sent to the PCP and placed in the record. The current assessments concludes that none of the individuals are capable of "self-medication" as of 5/2012. The IPP will reflect the individuals' abilities to participate in the individually identified tasks and the DSPs will document that as part of their program and data collection on the programs. ...5-30-13 display will have their self medication programs modified to reflect their potential for growth. The review process will be documented by the RN...5-30-13 | |

Health Regulation & Licensing 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 03/27/2013 | |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| I 436 | <p>Continued From page 13</p> <p>approximately 7:00 p.m., Resident #4 was observed playing a video game with the use of a hand held device. Observation of the medication administration on March 25, 2013, beginning at 5:43 p.m., revealed the licensed practical nurse (LPN, Staff #7) prepared Resident #4's medications. The nurse punched and measured Resident #4's medications into a medication cup. Continued observation at 7:22 p.m., revealed Staff #7 handed the resident his medications. The medications consisted of Simvastin and Desmopressin. She then handed the resident a cup of water mixed with Fiber Veg Lax. At 7:23 p.m., Resident #4 asked Staff #7 for his eye drops as she began to walk away. Staff #7 then indicated she would come back with his eye drops. At 7:49 p.m., Staff #7 applied Refresh Drops and Refresh Lucri lube to both his eyes then administered Nasonex in each nostril.</p> <p>On March 25, 2013, at approximately 8:05 p.m., Staff #7 stated that Resident #4 was capable of being trained to administer his Nasonex and participate in a self medication administration program.</p> <p>On March 27, 2013, at approximately 5:00 p.m., review of Resident #4's Self Administration of Medication Assessment Form, dated May 8, 2012, revealed the resident "is not recommended for the self administration of medication training program at this time." Further review revealed the resident was not able to name the medications he received.</p> <p>The facility failed to afford Resident #4 the opportunity to participate with self medication to the extent of his ability</p> | I 436 | | |

Health Regulation & Licensing 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 03/27/2013 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| I 473 | Continued From page 14 | I 473 | | |
| I 473 | <p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure that all drugs regimens that were not administered timely, were reported to the prescribing physician, for three of three residents in the sample. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>During the evening medication administration, the licensed practical nurse (LPN, Staff #7) failed to administer medications in accordance with physician's orders, as follows:</p> <p>1. On March 25, 2013, at approximately 7:00 p.m., Staff #7 stated that Resident #1's "medications were going to be late." She administered Resident #1's medications, at 7:17 p.m. His medications consisted of Topiramate, Trileptal, Oxcarbazepine, Levetiracetam, Keppra, Dilantin, Folic Acid, and Docusate.</p> <p>On March 25, 2013, at approximately 8:15 p.m., review of the resident's medication administration record (MAR) and physician's order sheets (POS) dated March 1, 2013, revealed the aforementioned medications were prescribed for 6:00 p.m. administration.</p> <p>2. Continued observation, at 7:22 p.m., revealed Staff #7 administered Resident #4's medications. The medications consisted of Simvastatin,</p> | I 473 | <p>3522.4</p> <p>BRA will retrain the medication administration nurses to ensure that timely feedback is provided if they are projected to be late for med passing. A discussion will be held with the PCP/designee for Specialty MDs to extend the times for passing meds to (i.e. 7am—between 6a and 8a) and if for another reason such as the individual is detained somewhere, nursing will obtain an order to provide meds when outside the documented times on the MARs (i.e. outside the new two hour window allowed). The RN will provide the training... 5-7-13</p> <p>The RN has already provided education and verbal reinforcement to the relevant LPNs.</p> <p>Additionally, the PCP and RNx2/LPNs will discuss the medication regimens of all of the individuals to include:</p> <p>1-identifying any medication that requires definitely fixed times such as diabetic meds so that they are taken timely in relation to meals, blood sugar testing, and meds, or other medications that require a very specific time structure due to blood levels.</p> <p>2-reviewing all meds to provide safety as to duplication, side effects, interactions, and reducing the quantity if possible and still obtain the outcomes desired</p> <p>3-in case of an emergency for nursing, staggering times will be an option and put in writing before the end of the day in which it occurs.</p> <p>4-BRA will maintain the integrity of the medication regimens for all of the individuals with the goal being that the individual achieves the desired outcome of the medication and the documentation of the time is accurate within the two hour window. 5-15-13</p> <p>BRA continues to maintain a strategy to train DSP supports to pass medications and plan to have a number of staff trained in each location by... 12-30-13</p> <p>The error (am to pm) for Client #2's Polyethylene was corrected; an RN and the administrative support LPN will audit the MARs each month prior to distribution. Those MARS are placed into the books prior to the 1st of each month and a copy sent to the QA/RN to review. The goal is always 100% accuracy for all medication involved documents. The 3 nurses involved with the initial review and checking have discussed the situation and will also solicit input from the med pass nurses as they use and review the newly placed MARS 5-15-13</p> | |

Health Regulation & Licensing 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 03/27/2013 |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| I.473 | <p>Continued From page 15</p> <p>Desmopressin and Fiber Veg Lax. At 7:23 p.m., Resident #4 asked Staff #7 for his eye drops as she began to walk away. Staff #7 then indicated she would come back with his eye drops. At 7:49 p.m., the LPN applied Refresh Drops and Refresh Lucri lube to both his eyes then administered Nasonex in each nostril.</p> <p>On March 25, 2013, at approximately 8:20 p.m., review of the resident's medication administration record (MAR) and physician's order sheets (POS) dated March 1, 2013, revealed the aforementioned medications were prescribed for 6:00 p.m. administration.</p> <p>Interview with Staff #7 on March 25, 2013, at approximately 8:00 p.m., confirmed that Resident #4's aforementioned medications were not administered timely.</p> <p>3. Resident #2 was observed being administered his medications on March 25, 2013, at 6:54 p.m. The medications consisted of Keppra, Hydroxyzine, Calcium, Lyrica, Tegretol and Polyethylene.</p> <p>On March 25, 2013, beginning at approximately 8:25 p.m., review of Resident #2's POS showed the Polyethylene was prescribed for 6:00 a.m. administration. [Note: All other medications were prescribed for 6:00 p.m. administration.] The resident's MAR, however, showed someone had changed the "am" to a "pm."</p> <p>Interview with the registered nurse consultant (Staff #4) on March 27, 2013, at approximately 11:00 a.m., stated that Resident #2's Polyethylene was prescribed for 6:00 a.m. Further interview revealed that the primary care physician was not notified of the aforementioned</p> | I.473 | | |

Health Regulation & Licensing 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 03/27/2013 |
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| I 473 | Continued From page 16 findings. | I 473 | | | |

Health Regulation & Licensing 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 03/27/2013 |
|--------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|-----------------------------------------------------|

| | |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 |
|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

| | | | | |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|

| | | | | |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| R 000 | <p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from March 25, 2013 through March 27, 2013. A sample of three clients was selected from a population of five males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with one client, one guardian, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p> | R.000 | <p>R125</p> <p>As mentioned by the surveyor, a background check capturing data from the county in Kentucky that was missed initially was completed and presented before the close of the survey and it demonstrated no disqualifying offenses. BRA assumed that the prior review captured all necessary counties but the surveyor's research demonstrated that it did not. Future checks will cover all jurisdictions making this issue moot...5-1-13</p> | |
| R 125 | <p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for individuals with intellectual disabilities (GHID) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 1 out of 19 direct support staff. (Staff #17)</p> <p>The finding includes:</p> | R.125 | | |

Health Regulation & Licensing Administration

Anne F. Gardo
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrative

(X6) DATE

4/29/13

Health Regulation & Licensing 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 03/27/2013 |
| NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4629 NH BURROUGHS AVE, NE WASHINGTON, DC 20019 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 125 | Continued From page 1 On March 27, 2013, at approximately 2:00 p.m., review of the personnel record for Staff #17 revealed that a statewide background check for Maryland and a background check covering Jefferson County, Kentucky had been documented on March 1, 2012. However, his employment application form, dated February 28 2012, indicated that he had been employed in Frankfort (Franklin County), Kentucky from June 1999 until January 2012. There was no evidence that a background check had been obtained in that jurisdiction. This was immediately brought to the attention of the facility's special projects assistant (Staff #3) who was facilitating the review. On March 27, 2013, at 3:37 p.m., the special projects assistant presented a background check for Staff #17 that covered Franklin County, Kentucky. The date on the background check was March 27, 2013. She confirmed that she had obtained the background check that afternoon. [Note: The background check effectively cleared the employee of any relevant criminal convictions.] | R 125 | | |