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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G134	A. BUILDING _____ B. WING _____	C 12/14/2011

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

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

Received 1/3/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 000 INITIAL COMMENTS

The Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received a complaint via e-mail on December 13, 2011, from the Department on Disability Services (DDS). Attached to the e-mail was the report of an onsite visit dated December 9, 2011, completed by DDS. The complainant identified the following concern:

Allegation #1: Client #1 had not received Oxycarbamezepine 900 mg twice daily as prescribed by the primary care physician since September 2011.

HRLA Findings: On December 14, 2011, interview and review of physician's orders revealed Client #1 was prescribed Oxcarbazepine 900 mg by mouth twice daily for seizure management. On December 14, 2011, interview and review of the October 2011 MAR revealed Client #1 received 750 mg by mouth twice a day from October 1, 2011 through October 31, 2011. Conclusion: This allegation was substantiated. See W 322 and W 368

An investigation was initiated at the facility on December 14, 2011, to verify compliance with the basic standards of practice and ICF/ID regulatory requirements in governing body and client protection.

The findings of the investigation were based on observations at the group home, interview with group home nursing staff, and a review of client and administrative records, including the unusual incident reports.

W 000

000

It should be noted that Client #1's Oxcarbazepine regimen was 750 mg twice daily prior to his Hospitalization at Howard University Hospital from 7-26-11 through 8-1-11. He was increased to 900 mg twice daily as recommended by Howard (1x month). It should also be noted that he had been seen by Neurology on 6-14-11, no changes in his medication regimen was suggested and he was recommended to return in 6 months. Client #1 takes three other medications to treat his seizure disorder (Dilantin, Keppra and Trileptal). His hospital emergency admission to Providence from 8-31-11 to 9-7-11 was based on the Dilantin reaching toxic levels. All of these factors were taken into consideration in adjusting the seizure medication regimen.

It should also be noted that in a three month period, Client #1 was seen on an emergency basis at Howard University Hospital, Providence, Georgetown and Washington Hospital Center each based on the particular circumstances that existed on the day of the event. His undercuts continuity of medical support and in the future, BRA will attempt to ensure that Georgetown is used on a consistent basis because his primary, treating physician is there and to establish a partnership with one entity in treating this problem.

The decision to move the Oxcarbazepine regimen back to 750 mg was based partly on the recommendation of Georgetown upon his discharge on 9-14-11. The RN at the time failed to properly document follow up in a number of ways that will be addressed later in the responses. This RN has been replaced by two that have extensive ICF/MR experience and who are revising the systems to eliminate such issues in the future...12-30-11.

W 322 483.460(a)(3) PHYSICIAN SERVICES

W 322

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Linda Graham	QIDP	01/06/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G134	A. BUILDING _____ B. WING _____	C 12/14/2011

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

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

W 322 Continued From page 1

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that the client received prescribed medications for seizure management for one of one client in the investigation. (Client #1).
The finding includes:
[Cross Refer to W 368] Interview with the facility's nurse and the review of medical records on December 14, 2011, that after Client #1's Oxcarbazepine was decreased from 900 mg twice a day to 750 mg twice a day on September 15, 2011, the client had two emergency hospital admissions for seizure activity (September 18 to September 26, 2011 and October 5 to October 11, 2011).
There was no documented evidence Client #1 received Oxcarbazepine 900 mg twice a day after September 14, 2011, as prescribed by the physician.

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that medications were administered in compliance with physicians' orders for one of one client in the investigation. (Client #1).

W 322

W322

The Oxcarbazepine regimen was changed back to 750 mg twice daily per Georgetown's recommendation. The PCP believes that this level and the present regimen for the three other seizure medications should be maintained and monitored. There was a failure to properly document the change back to 759mg by the erstwhile RN. The existing regimen of 900 mgs was discontinued on the physician's orders. The regimen consisted of a 600 mg pill and a 300 mg pill and both are indicated as discontinued on 9-15-11 on the physician's orders. The RN should have written a new order that reflected a 600 mg pill and a 150 mg pill totaling the new regimen of 750 mg but instead she indicated "750 mg" on the MAR record instead of properly breaking it up both on the physician's orders and MAR forms. Medication nurses properly provided 750 mg as per the new order beginning 9-15-11 pm dose but the RNs revisions were incomplete and unclear. They have been corrected by the new RN team...12-30-11

Follow up with Neurology will be scheduled by... 1-12-12
The Neurologist will be informed about all recent developments including the temporary increase in the Oxcarbazepine from the 750 BID that was in place during his last visit in June 2011 to the 900 mg BID that was suggested by Howard. The PCP will make any future adjustments based on the Neurology feedback...1-20-12

W 368

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G134	A. BUILDING _____ B. WING _____	C 12/14/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 2 The findings include: 1. Review of Client #1's, September 2011 physician's orders on December 14, 2011, reflected the client was prescribed Oxcarbazepine 900 mg by mouth twice daily for seizure management. A review of the September 2011 Medication Administration Record (MAR) revealed Client #1 received Oxcarbazepine 750 mg by mouth twice a day from September 15, 2011, through September 30, 2011. It should be noted that continued review of the client's MAR revealed that on September 15, 2011 at 6:00 p.m., Nurse #1 initialed that the client received 600 mg of Oxcarbazepine. Further review of the MAR revealed another nurse (Nurse #2) documented that the client was administered 750 mg of Oxcarbazepine on the same day and time (September 15,2011 at 6:00 p.m.) 2. Review of Client #1's, October 2011 physician's orders on December 14, 2011, reflected the client was prescribed Oxcarbazepine 900 mg by mouth twice daily for seizure management. A review of the October 2011 MAR revealed Client #1 received 750 mg by mouth twice a day from October 1, 2011 through October 31, 2011. Interview with the facility's nurse on December 14, 2011, confirmed Client #1 was only receiving Oxcarbazepine 750 mg by mouth twice a day on the aforementioned dates.	W 368	W368 1. The change back to 750 mg per Georgetown's recommendation was discussed with the PCP who agreed with the change but there was a failure by the RN to document her discussion with the PCP. 2. Client #1 received 750 mg per the order but again, the erstwhile RN made an unclear and incomplete revision in the MAR record and on the physician's orders. She correctly discontinued the 600 mg pill regimen and the 300 mg pill regimen consistent with the 900 mg order. However, she failed to complete a hand-written new order that reflected 600mg and 150 mg pills totaling 750. Instead she indicated "750 mg" which can be misinterpreted and was by the surveyor. The October 2011 physician's orders still reflected the 900 mg regimen because pharmacy did not make the formal change by 10-1-11. The RN should have hand corrected the orders, signed them off and had them reviewed by the PCP and signed off. She did not, so the October physician's orders did not reflect the proper, current regimen although the MAR record does and the medication nurses actually administered the 750 mg BID regimen consistently. The MAR record and physician's orders were modified by pharmacy to reflect the 750 mg regimen by 11-1-11. The new RN team is reviewing all of the physician's orders and MARS to ensure that they are clean, clear and accurately reflect the current medication and treatment regimens of each person supported in the home. Process completed by...1-6-12 Additionally the BRA RN team is revising the seizure documentation form for direct support staff to make it easier for them to document what they observe during seizure activity. Staff will be trained on the new form by...1-15-11 Also, the new RN team is reviewing the Health Passports for each person supported to ensure that they accurately reflect current information in all areas but particularly the medication and treatment regimens. The RNs will amend the documents as required and will amend them within 24 hours of a change in the medication or treatment regimen of any individual supported...1-15-12 The new RN team will ensure that the PCP is notified about a suggested change in the medication or treatment regimen of any individual supported the same day that recommendation is made and will ensure that the PCP receives by fax or email, any document needed to aid in decision-making on the proposed change(s)...1-6-12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-088	A. BUILDING _____ B. WING _____	C 12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	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	I 000		

The Department of Health/Health Regulation and Licensing Administration (DOH/HRLA) received a complaint via e-mail on December 13, 2011, from the Department on Disability Services (DDS). Attached to the e-mail was the report of an onsite visit dated December 9, 2011, completed by DDS. The complainant identified the following concern:

Allegation #1: Resident #1 had not received Oxycarbamezepine 900 mg twice daily as prescribed by the primary care physician since September 2011.

HRLA Findings: On December 14, 2011, interview and review of physician's orders revealed Resident #1 was prescribed Oxcarbazepine 900 mg by mouth twice daily for seizure management. On December 14, 2011, interview and review of the October 2011 MAR revealed Resident #1 received 750 mg by mouth twice a day from October 1, 2011 through October 31, 2011.
Conclusion: This allegation was substantiated.
See W 322 and W 368

An investigation was initiated at the facility on December 14, 2011, to verify compliance with the basic standards of practice and ICF/ID regulatory requirements in governing body and resident protection.

The findings of the investigation were based on observations at the group home, interview with group home nursing staff, and a review of resident and administrative records, including the unusual incident reports.

000

It should be noted that Client #1's Oxcarbazepine regimen was 750 mg twice daily prior to his Hospitalization at Howard University Hospital from 7-26-11 through 8-1-11. He was increased to 900 mg twice daily as recommended by Howard (1x month). It should also be noted that he had been seen by Neurology on 6-14-11, no changes in his medication regimen was suggested and he was recommended to return in 6 months. Client #1 takes three other medications to treat his seizure disorder (Dilantin, Keppra and Trileptal). His hospital emergency admission to Providence from 8-31-11 to 9-7-11 was based on the Dilantin reaching toxic levels. All of these factors were taken into consideration in adjusting the seizure medication regimen.

It should also be noted that in a three month period, Client #1 was seen on an emergency basis at Howard University Hospital, Providence, Georgetown and Washington Hospital Center each based on the particular circumstances that existed on the day of the event. His undercuts continuity of medical support and in the future. BRA will attempt to ensure that Georgetown is used on a consistent basis because his primary, treating physician is there and to establish a partnership with one entity in treating this problem.

The decision to move the Oxcarbazepine regimen back to 750 mg was based partly on the recommendation of Georgetown upon his discharge on 9-14-11. The RN at the time failed to properly document follow up in a number of ways that will be addressed later in the responses. This RN has been replaced by two that have extensive ICF/MR experience and who are revising the systems to eliminate such issues in the future...12-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-088	A. BUILDING _____ B. WING _____	C 12/14/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 1	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		

Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included treatment services, and services designed to prevent deterioration or further loss of functioning by the resident for one of one resident in the investigation. (Resident #1)

The findings include:

1. Review of Resident #1's, September 2011 physician's orders on December 14, 2011, reflected the resident was prescribed Oxcarbazepine 900 mg by mouth twice daily for seizure management. A review of the September 2011 Medication Administration Record (MAR) revealed Resident #1 received Oxcarbazepine 750 mg by mouth twice a day from September 15, 2011, through September 30, 2011. It should be noted that continued review of the resident's MAR revealed that on September 15, 2011 at 6:00 p.m., Nurse #1 initialed that the resident received 600 mg of Oxcarbazepine. Further review of the MAR revealed another nurse (Nurse #2) documented that the resident was administered 750 mg of Oxcarbazepine on the same day and time (September 15,2011 at 6:00 p.m.)

1 The change back to 750 mg per Georgetown's recommendation was discussed with the PCP who agreed with the change but there was a failure by the RN to document her discussion with the PCP.

2 Client #1 received 750 mg per the order but again, the erstwhile RN made an unclear and incomplete revision in the MAR record and on the physician's orders. She correctly discontinued the 600 mg pill regimen and the 300 mg pill regimen consistent with the 900 mg order. However, she failed to complete a hand-written new order that reflected 600mg and 150 mg pills totaling 750. Instead she indicated "750 mg" which can be misinterpreted and was by the surveyor. The October 2011 physician's orders still reflected the 900 mg regimen because pharmacy did not make the formal change by 10-1-11. The RN should have hand corrected the orders, signed them off and had them reviewed by the PCP and signed off. She did not, so the October physician's orders did not reflect the proper, current regimen although the MAR record does and the medication nurses actually administered the 750 mg BID regimen consistently.

The MAR record and physician's orders were modified by pharmacy to reflect the 750 mg regimen by 11-1-11.

The new RN team is reviewing all of the physician's orders and MARS to ensure that they are clean, clear and accurately reflect the current medication and treatment regimens of each person supported in the home. Process completed by . 1-6-12

Additionally the BRA RN team is revising the seizure documentation form for direct support staff to make it easier for them to document what they observe during seizure activity. Staff will be trained on the new form by . 1-15-11

Also, the new RN team is reviewing the Health Passports for each person supported to ensure that they accurately reflect current information in all areas but particularly the medication and treatment regimens. The RNs will amend the documents as required and will amend them within 24 hours of a change in the medication or treatment regimen of any individual supported . 1-15-12

The new RN team will ensure that the PCP is notified about a suggested change in the medication or treatment regimen of any individual supported the same day that recommendation is made and will ensure that the PCP receives by fax or email, any document needed to aid in decision-making on the proposed change(s) 1-6-12

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-088	A. BUILDING _____ B. WING _____	C 12/14/2011

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 2 2. Review of Resident #1's, October 2011 physician's orders on December 14, 2011, reflected the resident was prescribed Oxcarbazepine 900 mg by mouth twice daily for seizure management. A review of the October 2011 MAR revealed Resident #1 received 750 mg by mouth twice a day from October 1, 2011 through October 31, 2011. Interview with the facility's nurse on December 14, 2011, confirmed Resident #1 was only receiving Oxcarbazepine 750 mg by mouth twice a day on the aforementioned dates.	I 401		