

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

PRINTED: 08/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from June 22, 2011 through June 23, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of six males with profound level of intellectual disabilities.

The findings of the survey were based on observations at the group home, one day program, interviews staff and the review of clinical and administrative records, including incident reports.

*Received 8/22/11*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
800 North Capitol St., N.E.  
Washington, D.C. 20002

W 194 483.430(e)(4) STAFF TRAINING PROGRAM

W 194

Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

This STANDARD is not met as evidenced by: Based on observations, interviews and record verification, the facility failed to ensure staff demonstrated competency in implementing clients' active treatment programs as written, for one of the three clients in the sample. (Client #2)

The finding includes:

On June 22, 2011, at 3:59 p.m., a direct support professional (DSP) was observed putting a splint on Client #2's left hand and fingers. Minutes later, the DSP indicated that the splint was used to loosen the client's fingers and he should wear it for one hour each day. At 5:00 p.m., the DSP removed Client #2's left hand splint.

W194  
This Standard will be met as evidenced by:

Review of record indicated that all DSP were trained on client #2's wearing of his hand Splint on 2/15/11  
A refresher training was completed by QIDP on 7/12 11.  
QIDP will follow up with training to reinforce the appropriate use of adaptive assistive device, QIDP will periodically monitor program implementation to ensure compliance with the use of #2's adaptive assistive equipment; Such actions will be documented in the QMRP notes.  
In addition, all other Individuals including Client#2 adaptive equipment will be monitored by QDDP and RD for the home. All concerns will be communicated to the DRS and Adaptive Equipment Coordinator

7/12/11

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*[Signature]* Director of Residential Services  
TITLE  
8/5/11  
(X6) DATE:

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

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W 194 Continued From page 1  
Record review on June 23, 2011, at 3:55 p.m., revealed that Client #2 had a program objective which stated "<client's name> will tolerate the splint wearing scheduled as specified below: Wednesday 6-8 p.m., Saturday 10 a.m. - 12 p.m., and Sunday 10 a.m. - 12 p.m."

W 194

Interview with the qualified intellectual disabilities professional (QIDP) on June 23, 2011, at 4:10 p.m., revealed that Client #2's schedule should be adhered to mentioned above. She further noted that the staff failed to implement the scheduled as written.

W 242 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN

W 242

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement a self-feeding training objective, for one of the three clients in the sample. (Client #3)

The finding includes:

On June 22, 2011, beginning at 12:51 p.m., a direct support staff was observed spoon feeding Client #3 his lunch. The spoon had a built-up handle. At 1:01 p.m., the Residential Director,

W242

This Standard will be met as evidenced by:

7/12/11

The QIDP provided refresher training to all staff on 7/12.11.

The Speech Pathologist will provide additional training to ensure staffs follow up with feeding guidelines as written and if warranted, speech pathologist will modify current mealtime protocol to clearly describe the degree of feeding support needed for client #3 during mealtime.

As previously mentioned, the QDDP will provide routine monitoring of meals to compliance with mealtime protocol as written.

The Speech Pathologist modified the mealtime protocol for client#3 Training has been completed by Speech Pathologist.

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			(X5) COMPLETION DATE

W 242 Continued From page 2

W 242

stepped in and continued feeding the client his lunch with the same spoon. At no time was staff observed placing the spoon in Client #3's hand or otherwise encouraging him to participate in the spooning (self-feeding) process. At 10:34 a.m., the daytime nurse was observed spoon feeding him pudding for a morning snack with a plastic spoon. Later that evening, beginning at 5:24 p.m., a direct support staff person was observed providing Client #3 hand over hand assistance throughout his dinner meal, using the adaptive spoon with the built-up handle. The client accepted the hand over hand assistance throughout the meal.

On June 23, 2011, at 4:20 p.m., review of Client #3's Individual Support Plan (ISP) dated October 12, 2010, verified that the client was prescribed a built-up handled coated teaspoon. The ISP, however, did not describe the nature or degree of support that staff was to provide with using the spoon. At 4:24 p.m., review of the client's Mealttime Protocol, dated June 20, 2011, revealed the following: "built-up handle coated spoon (use soft foam tubing to build up handle) ... Assisted by staff ... Allow 1/2 to 1 teaspoon or less per serving. Allow him to swallow before presenting another spoonful." The protocol did not provide further instructions regarding the assistance that staff was to provide during a meal.

On June 23, 2011, at 4:25 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that staff was expected to provide hand over hand assistance; "everybody is supposed to be participating." She further stated that staff would spoon feed him if he were to refuse to eat with hand over hand assistance, to

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W 242 Continued From page 3  
ensure adequate nutritional intake. Upon examining Client #3's ISP and Mealtime Protocol, the QIDP acknowledged that his training and support needs for self-feeding were not addressed.

W 242

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION  
As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

W 249

W249  
This Standard will be met as evidenced by:  
  
Cross reference W194

7/12/11

This STANDARD is not met as evidenced by:  
Based on observation, staff interview and record verification, the facility's staff failed to ensure that clients' active treatment was implemented as written, for one of the three clients in the sample. (Client #2)

The finding includes:

[Cross-refer to W194] On June 22, 2011, observations and interviews revealed that staff applied Client #2's left hand splint for only one hour. Review of his program, however, revealed that he was to wear the splint for two hours.

W 382 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING

W 382

The facility must keep all drugs and biologicals locked except when being prepared for administration.

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W 382 Continued From page 4

W 382

W382

7/12/11

This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility failed to ensure that medications were supervised at all times during medication administration, for three of the three clients residing the facility. (Clients #3, #4 and #6)

This Standard will be met as evidenced by:

On 6/22/11 the RN has provided additional training to all nurses on nursing protocols that included medication administration monitoring/supervision, RN will continue on-going training and monitoring of protocols/practices to ensure compliance.

The finding includes:

On June 22, 2011, at 3:30 p.m., the licensed practical nurse (LPN) unlocked and opened the medication closet, removed several bubble packs of medication, placed the medications onto a rolling cart, and walked into the kitchen. While in the kitchen, the LPN prepared three cups of water and returned to the cart at 3:35 p.m. The medications remained on the cart while staff walked throughout the facility.

During the interview on June 22, 2011, at 4:10 p.m., the LPN acknowledged that all medications should have been locked except when being prepared for administration.

At the time of the survey, there was no evidence that each medication had been secured, except for when being prepared for administration.

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1 000 INITIAL COMMENTS 1 000

A licensure survey was conducted from June 22, 2011 through June 23, 2011. A random sample of three residents was selected from a population of six males with profound level of intellectual disabilities.

The findings of the survey were based on observations at the group home, one day program, interviews staff and the review of clinical and administrative records, including incident reports.

1 399 3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS 1 399

Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:

(i) Speech and language therapy; and...

This Statute is not met as evidenced by:  
Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHPID, for one of the twenty-three consultants, as required by District of Columbia law, in the following discipline or area:

3520.2(1):  
This status will be met as evidenced by:  
Speech and Language Pathologist has a current DC license and she is currently waiting to receive her license from the licensing office. The GHPID will provide routine monitoring of clinical record to ensure compliance with standard as set forth.

7/13/11

Health Regulation & Licensing Administration  
*[Signature]* Director of Residential Services  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE  
8/5/11

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I 399	Continued From page 1  (i) Speech and Language Therapy.  The finding includes:  On June 23, 2011, beginning at 2:10 p.m., review of the personnel records revealed the GHPID failed to have evidence that the speech language pathologist under contract had a current license to practice in the District of Columbia. The record indicated that the speech language pathologist applied for a license on May 11, 2011.  At approximately 12:20 p.m., the qualified intellectual disabilities professional (QIDP) acknowledged that there was no evidence of a professional license for the speech pathologist. She confirmed that the consultant had performed assessments for Residents #1 and #2 on February 15, 2011 and August 10, 2010, respectively. She further confirmed that the consultant had provided in-service training for staff on February 15, 2011, after having revised the formal communication training programs for all 6 of the residents of the GHPID.  Note: Two other facilities operated by the same governing body were cited for this deficiency on April 23, 2010 and April 8, 2011.	I 399		
I 422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility's staff failed to ensure that residents' training objectives were implemented in accordance with their Individual Support Plan	I 422		

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1422 Continued From page 2

(ISP), for one of the three residents in the sample. (Resident #2)

The finding includes:

On June 22, 2011, at 3:59 p.m., a direct support professional (DSP) was observed putting a splint on Resident #2's left hand and fingers. Minutes later, the DSP indicated that the splint was used to loosen the resident's fingers and he should wear it for one hour each day. At 5:00 p.m., the DSP removed Resident #2's left hand splint.

Record review on June 23, 2011, at 3:55 p.m., revealed that Resident #2 had a program objective which stated "<resident's name> will tolerate the splint wearing scheduled as specified below: Wednesday 6-8 p.m., Saturday 10 a.m. - 12 p.m., and Sunday 10 a.m. - 12 p.m."

Interview with the qualified intellectual disabilities professional (QIDP) on June 23, 2011, at 4:10 p.m., revealed that Resident #2's schedule should be adhered to mentioned above. She further noted that the staff failed to implement the scheduled as written.

3521.3:  
This statute will be met as evidenced by:

7/12/11

Review of record indicated that all DSP were trained on client #2's wearing of his hand Splint on 2/15/11  
A refresher training was completed by QIDP on 7/12/11.  
QIDP will follow up with training to reinforce the appropriate use of adaptive assistive device, QIDP will periodically monitor program implementation to ensure compliance with the use of #2's adaptive assistive equipment; Such actions will be documented in the QMRP notes.  
In addition, all other Individuals including Client#2 adaptive equipment will be monitored by QDDP and RD for the home. All concerns will be communicated to the DRS and Adaptive Equipment Coordinator

1430 3521.7(a) HABILITATION AND TRAINING 1430

The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:

(a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils);

This Statute is not met as evidenced by:  
Based on observations, interview, and record review, the Group Home for Persons with

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I 430 Continued From page 3

I 430

7/12/11

Intellectual Disabilities (GHPID) failed to teach residents to use adaptive feeding equipment, for one of the three residents in the sample. (Resident #3)

The finding includes:

On June 22, 2011, beginning at 12:51 p.m., a direct support staff was observed spoon feeding Resident #3 his lunch. The spoon had a built-up handle. At 1:01 p.m., the Residential Director, stepped in and continued feeding the resident his lunch with the same spoon. At no time was staff observed placing the spoon in Resident #3's hand or otherwise encouraging him to participate in the spooning (self-feeding) process. At 10:34 a.m., the daytime nurse was observed spoon feeding him pudding for a morning snack with a plastic spoon. Later that evening, beginning at 5:24 p.m., a direct support staff person was observed providing Resident #3 hand over hand assistance throughout his dinner meal, using the adaptive spoon with the built-up handle. The resident accepted the hand over hand assistance throughout the meal.

On June 23, 2011, at 4:20 p.m., review of Resident #3's Individual Support Plan (ISP) dated October 2, 2010, verified that the resident was prescribed a built-up handled coated teaspoon. The ISP, however, did not describe the nature or degree of support that staff was to provide with using the spoon. At 4:24 p.m., review of the resident's Mealtime Protocol, dated June 20, 2011, revealed the following: "built-up handle coated spoon (use soft foam tubing to build up handle) ... Assisted by staff ... Allow 1/2 to 1 teaspoon or less per serving. Allow him to swallow before presenting another spoonful." The protocol did not provide further instructions

3521.7(a):  
This statute will be met as evidenced by:  
The QDDP provided refresher training to all staff on 7/12/11.  
The Speech Pathologist will provide additional training to ensure staffs follow up with feeding guidelines as written and if warranted, speech pathologist will modify current mealtime protocol to clearly describe the degree of feeding support needed for client #3 during mealtime. The QDDP will provide routine monitoring of meals to compliance with mealtime protocol as written

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I 430 Continued From page 4 I 430

regarding the assistance that staff was to provide during a meal.

On June 23, 2011, at 4:25 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that staff was expected to provide hand over hand assistance; "everybody is supposed to be participating." She further stated that staff would spoon feed him if he were to refuse to eat with hand over hand assistance, to ensure adequate nutritional intake. Upon examining Resident #3's ISP and Mealtime Protocol, the QIDP acknowledged that his training and support needs for self-feeding were not addressed