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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from 3/10/2010 through 3/12/2010. The survey was initiated utilizing the fundamental survey process.</p> <p>A random sampling of three clients was selected from a residential population of six females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the client and administrative records, including the incident reports.</p>	W 000	<p>W120</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> The QMRP visited the day program on 4.8.10 and conducted an inservice training on behalf of the person (#1) for the Case Manager and Nurse assigned at the day program. In turn they reported that training would be conducted with staff to include but not limited to; mealtime protocols, feeding techniques, use of dycem mat, and positioning during meals. Also, during the visit the dycem mat was observed in use and staff continued to prompt her to maintain good posture during meals. <p>The QMRP in consultation with the IDT will explore other interventions/adaptive equipment to support good posture during mealtimes.</p>	
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure outside services met the needs of two of the three sampled clients. (Clients #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Observation at Client #1's day program on 3/11/2010, at 12:50 p.m. revealed she was sitting at a small table eating her lunch. Her attending staff (Staff #1) placed a large bib around her neck and then placed the lower end of the bib on the table in front of her. Another staff (Staff #2) brought Client #1's plate of food and placed it on top of her bib. Staff #1 then adjusted Client #1's seat, so that she sat closer to the table. Although the plate had been placed on top of the large bib, it slid toward the client, and from side to side, as 	W 120	<ol style="list-style-type: none"> Reference response to W120, #1, 	4.15.10 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE DRS	(X8) DATE 4/19/10
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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.

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W 120	<p>Continued From page 1 she ate her meal.</p> <p>On 3/11/2010, at 12:55 p.m., Staff #1 indicated that placing the large bib under Client #1's plate of food during meals prevented her from spilling food on her clothing.</p> <p>At the time of the survey, there was no evidence the facility ensured that the day program provided Client #1 with an appropriate place mat for use during her meals, to encourage her to eat in a manner consistent with her developmental level.</p> <p>2. On 3/11/2010, at 12:52 p.m., Staff #1 adjusted Client #1's seat, so that she sat closer to the table during her lunch. Although the client was observed to be able to sit in a more upright position, she leaned forward, placing her lower lip against the high sided plate of food as she began to eat. Staff was not observed to prompt the client to sit upright as she ate. The client placed large spoonfuls of food in her mouth at a steady pace, until she was almost finished eating her meal. As the client ate, her plate slid toward her, and from side to side on the table. No mealtime instructions or mealtime feeding protocol (MFP) were observed at the dining table for the client.</p> <p>Interview with Staff #1 on 3/11/2010, at 1:02 p.m., revealed Client #1 generally leans over to the plate to eat her food, and eats at a rapid, steady pace because she's a "good eater".</p> <p>On 3/12/2010 at approximately 12:07 p.m., interview with the facility's qualified mental retardation professional (QMRP) revealed the client has a MFP at the group home, which also should have been implemented by the day program staff. The QMRP acknowledged that she</p>	W 120		
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W 120	<p>Continued From page 2</p> <p>was not aware that the day program was not implementing the MFP as written and that she would immediately work to address the problem.</p> <p>Record review on 3/12/2010 at 12:15 p.m. revealed Client #1's Mealtime Feeding Protocol (MFP) dated 1/10/2010 recommended the following interventions:</p> <ul style="list-style-type: none"> (a) Ensure she sits at 90 degrees (b) Allow ½ to 1 teaspoonful at a time (c) Allow swallow before presenting another mouthful (d) Ensure the use of the Dycern mat <p>Review of the MFP dated 1/10/2010, revealed the day program failed to ensure the implementation of all four of the interventions listed above during Client #1's lunch on the afternoon of 3/11/2010.</p> <p>At the time of the survey, there was no evidence the facility ensured Client #1's MFP was implemented, as written by the day program.</p> <p>3. The facility failed to ensure Client #3's day program provided continuous active treatment using a voice output device to enhance her communication skills as evidenced below:</p> <p>Observation of Client #3 on 3/11/2010 at 8:00 a.m. at the group home, revealed staff asking her questions and telling her to press the buttons on the "Go Talk" communication device.</p> <p>On 3/11/2010 at 11:20 a.m., Client #3 was observed at her day program seated in her wheelchair, at a table with several of her peers. She was engaged by an instructor who assisted her to complete an arts and crafts project. As the</p>	W 120	<p>3. The QMRP met with the day program staff. The person's (#3) communication goal was modified and the communication device to increase communication skills.</p> <p>The QMRP will conduct follow-up visits to both day program sites to ensure that the mealtime protocols and communication objectives are being implemented as outlined. Documentation of visits will be maintained in the person's record.</p>	<p>4. 11.10 ongoing</p>
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W 120	<p>Continued From page 3</p> <p>instructor talked to the client, the client smiled broadly, but was unable to respond verbally.</p> <p>Interview with the client's assigned classroom instructor on 3/11/2010, at 11:24 a.m., revealed the client was non-verbal, but seemed to understand when persons were trying to communicate with her. The instructor revealed the client had a goal to increase her functional communication. The instructor also indicated that the client was involved in an exchange program, which was to help her express her wants and needs. Additional discussion with the instructor, however, revealed the client currently did not have an objective to receive training using a communication device (Go Talk or a Big Mac) at her day program.</p> <p>On 3/12/2010, at 9:25 a.m., interview with the day program case manager and the classroom instructor revealed Client #3 had a training objective during the previous individual support plan (ISP) year, which required her to use a Big Mac voice output device to express her basic wants and needs. According to the day program staff, the Big Mac was similar to a Go Talk device, however the client no longer used the Big Mac at the day program after the new treatment plan (2/2010) was implemented. During the discussion, the instructor presented a Big Mac voice output device with Client #3's name written on it. Interview with day program case manager and the QMRP on 3/12/2010, revealed that training using the Big Mac voice output device should have been included (continued) in the IPP for the client at the day program.</p> <p>On 3/11/2010, at 9:40 a.m., review of the day</p>	W 120	<p>W120, Continued...</p> <p>The QMRP will conduct follow-up visits to both day program sites to ensure that the mealtime protocols and communication objectives are being implemented as outlined. Documentation of visits will be maintained in the person's record.</p>	<p>4-16-10 ongdnh</p>
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W 120 Continued From page 4
program's speech and language pathologist's (SLP) communication progress note dated 1/8/2010 revealed, "[Client #3] actively participates during programming; she is benefiting from the programming that is provided. Recommendation: She should continue to receive programming to use her voice output device. Vocabulary should be monitored and expanded as needed."

W 120

At the time of the survey, there was no evidence the recommended objective designed to enhance Client #3's communication skills to express her wants, needs, and feelings while at the day program, was being implemented.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for two of the three clients in the sample. (Clients #1 and #3)

The findings include:

1. The QMRP failed to coordinate with Client #1's day program to ensure the accurate implementation of her mealtime time protocol. [See W120.1,2]

2. The QMRP failed to coordinate services to

W159

This Standard will be met as evidenced by:

1. Reference response to W120 #1.
2. Reference response to W120#3.

4. 16.10 ongoing

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W 159	Continued From page 5 ensure that Client #3 received continuous active treatment using her voice output box at her day program. Interview with the QMRP on 3/11/2010 at 3:39 p.m., revealed Client #3 did not take her "Go Talk 4" communication Device to the day program. According to the QMRP, in the past, the day program had implemented the day program speech and language pathologist's objective, which provided training using the Big Mac voice output box. The QMRP, however, was not aware that the use of the Big Mac had been discontinued at the day program after the new Individual Support Plan(ISP) was held on 1/29/2010. Interview with day program case manager and the QMRP on 3/12/2010 revealed that training using the Big Mac voice output device should have been included (continued) in the client's current day program IPP. On 3/11/2010 at 9:40 a.m., review of the day program's speech and language pathologist's (SLP) communication progress note dated 1/8/2010 revealed, "[Client #3] actively participates during programing; she is benefiting from the programming that is provided. Recommendation: She should continue to receive programming to use her voice output device. Vocabulary should be monitored and expanded as needed." At the time of the survey, there was no evidence the the QMRP had coordinated services with the day program to ensure recommendation to enhance Client #3's communication skills were implemented. [See W120.3]	W 159			
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436			

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W 436	<p>Continued From page 6</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the timely provision of assistive devices recommended by the interdisciplinary team for one of three clients in the sample. (Clients #1)</p> <p>The finding include:</p> <p>Observation on the evening of 3/11/2010, at 5:15 p.m., revealed Client #1 was seated at the dining room table for dinner. Her meal was served in a high sided plate, which was placed on a piece of cloth used as a place mat. The piece of cloth measured approximately 12 inches by 12 inches.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010, at approximately 12:22 p.m. acknowledged that staff should have provided Client #1 with a dycem mat to stabilize the plate, as the client ate. Further interview with the QMRP revealed she was not aware the residential staff had not provided Client #1 with her Dycem mat, as recommended for use during the meal. The QMRP further indicated she would retrain the staff to address the oversight immediately.</p> <p>Record review on 3/12/2010 at 12:07 p.m. revealed Client #1's Mealtime Feeding Protocol</p>	W 436	<p>W436</p> <p>This Standard will be met as evidenced by:</p> <p>QMRP was present during all of the evening meal and confirms that all equipment was present throughout the meal. In addition, the QMRP reported she was never informed by either surveyor that the dycem mat for person (#1) was missing on the evening of 3/11/10 as indicated.</p> <p>The QMRP/Coordinator/Nurses and other members of the IDT will continue to monitor mealtimes. QMRP will address all concerns in a timely manner and obtain assistive devices as recommended/approved by the IDT.</p>	<p>3.15.10 original</p>
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W 436	Continued From page 7 (MFP) dated 1/10/2010 recommended she be provided a Dycem mat during her meals. At the time of the survey, there was no evidence the facility ensured the consistent use of adaptive equipment recommended by the IDT for Client #1.	W 436		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for three of six clients residing at the home. (Clients #1, #3, and Client #4) The findings include: 1. On 3/10/2010, at approximately 7:00 p.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse her hands prior to administering medications to Client #4. However, LPN #1 touched the Medication Administration Records (MAR's), medication basket and then touched the rim of Client #4's medication cup. During a face to face interview with LPN #1 on 3/11/2010, at approximately 6:53 a.m., it was acknowledged after using hand sanitizer to cleanse her hands the LPN #1 touched the MAR's, medication basket and then touched the rim of Client #4's medication cup.	W 455		

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W 455	Continued From page 8 There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection. 2. On 3/10/2010, at approximately 8:00 p.m., LPN #1 was observed to use hand sanitizer to cleanse her hands prior to administering medications to Client #3. However, LPN #1 touched the tri-fold examination screen and then touched the rim of the medication cup Client #3 used to consume the medications. During a face to face interview with LPN #1 on 3/11/2010, at approximately 6:53 a.m., it was acknowledged that after using hand sanitizer to cleanse her hands, she touched the tri-fold examination screen and then touched the rim of the medication cup Client #3 used to consume the medications. There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	W 455	W455 This Standard will be met as evidenced: 1. Additional training was conducted by the RN for the LPN staff assigned to the home on universal precautions (hand-washing and maintaining good hygiene practices during medication administration). The RN will continue to conduct routine medication administration observations and monitor infection control techniques used by staff.	4.15.10 ongoing	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and staff interview, the facility failed to ensure meals were provided in the texture prescribed in her dietary orders for one of three sampled clients. [Client #1] The finding includes:	W 474			

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W 474	<p>Continued From page 9</p> <p>Observation on the evening of 3/11/2010 at 5:15 p.m. revealed Client #1 was seated at the dining room table for dinner. Her meal was pureed except for her string beans which were cut into pieces approximately ½ inch to 1 inch long. She was observed bent over with her lips touching the side of the high sided plate of food.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010 at approximately 12:20 p.m. revealed she was not aware the facility's staff had not finely chopped the string beans, as outlined in the MFP and written on her POS. The QMRP indicated she would have staff retrained to address the problem.</p> <p>Record review on 3/12/2010, at approximately 12:22 p.m. revealed Client #1's Mealtime Feeding Protocol (MFP) dated 1/10/2010 and her physician's order sheets (POS) dated 2/2010 recommended "String beans ... finely chopped". Information provided on her MFP and POS revealed the facility failed to ensure Client #1's string beans were finely chopped as prescribed during her dinner on the evening of 3/11/2010.</p> <p>Additional interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010 at approximately 12:20 p.m. revealed she was not aware the facility's staff had not finely chopped the string beans as outlined in the MFP and written on her POS. The QMRP indicated she would have staff retrained to address the problem.</p> <p>At the time of the survey, there was no evidence the facility ensured that each food was provided in the texture prescribed by the MFP and the POS.</p>	W 474	<p>W474</p> <p>This Standard will be met as evidenced by:</p> <p>The QMRP reports that the surveyor did not discuss any concerns regarding string beans. The QMRP will coordinate further training for all staff on mealtime protocols and diet consistencies. The QMRP and other designated staff will continue to monitor mealtimes, adaptive equipment, and meal textures and address concerns as they arise to ensure ongoing compliance with this standard.</p>	4.16.10 ongoing

Health Regulation Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from 3/10/2010 through 3/12/2010. A random sampling of three residents was selected from a residential population of six females with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the resident and administrative records, including the incident reports.	I 000	1090 3504.1 This Statute will be met as evidenced by:	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, with Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner and was free of accumulations of dirt, rubbish, and objectionable odors, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: An environmental inspection of the GHMRP was conducted on 3/11/2010, at approximately 1:15 p.m. The results of the inspection revealed the following: 1. Rust was observed on the ceiling vent in the bathroom adjacent to the bedroom shared by	I 090	1090 3504.1 This Statute will be met as evidenced by: 1. Rust observed on the ceiling vent has been evaluated and assessed by the maintenance department and repairs in the process of completion. 2. The lid was discarded. 3. Reference response to #1. Maintenance repairs, assessed, materials obtained, and scheduled repairs are in the process of completion. 4. Dirt behind the washer has been removed. 5. Reference responses to #1 and #3. Floor tiles will be replaced. 6. Bedroom closets, water stains, reference response to #1 and #3.	4.19.10 <i>ongoing</i>

Health Regulation Administration

[Signature]

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

TITLE
[Signature]

(X6) DATE

4.19.10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2010	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018		
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I 090	<p>Continued From page 1</p> <p>Residents #1 and #2.</p> <p>2. The trash can in the bathroom had a broken lid.</p> <p>3. In the bathroom adjacent to the bedroom of Residents #1 and #2, a large amount of a substance, which appeared to be glue, was observed on the wall tiles installed near the floor.</p> <p>4. In the laundry room, behind the washer, the baseboard was not secured to the wall. There was also an accumulation of dirt behind the washer.</p> <p>5. In the utility room, several floor tiles were cracked and had small pieces broken from them. There was also rust on the floor in front of the utility sink, located in the utility room.</p> <p>6. Water stains were observed on the ceiling of the bedroom closets of Resident #3 and #4.</p> <p>7. Broken bricks, pieces of wood, and sand were observed on the right side of the front yard of the GHMRP.</p> <p>These observations were acknowledged by the Qualified Mental Retardation Professional (QMRP) of the GHMRP during the environmental walk-through.</p>	I 090	<p>7. The broken pieces of wood and sand are residuals from the snow storm. Lawn crews will clear and clean during scheduled maintenance.</p> <p>The Facility Coordinator will continue to conduct environmental checks of the home, generate weekly maintenance requests as needed and track until completed. Staff are also encouraged to report all concerns as they arise.</p>	4.19.10 organy
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by:</p>	I 180		

Health Regulation Administration

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I 180	<p>Continued From page 2</p> <p>Based on observation, staff interview, and record review, Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for two of the three residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>1. The QMRP failed to coordinate with Resident #1's day program to ensure the accurate implementation of her mealtime time protocol as evidenced below:</p> <p>a. Observation at Resident #1's day program on 3/11/2010, at 12:50 p.m. revealed she was sitting at a small table eating her lunch. Her attending staff (Staff #1) placed a large bib around her neck and then placed the lower end of the bib on the table in front of her. Another staff (Staff #2) brought Resident #1's plate of food and placed it on top of her bib. Staff #1 then adjusted Resident #1's seat, so that she sat closer to the table. Although the plate had been placed on top of the large bib, it slid toward the resident, and from side to side, as she ate her meal.</p> <p>On 3/11/2010, at 12:55 p.m., Staff #1 indicated that placing the large bib under Resident #1's plate of food during meals prevented her from spilling food on her clothing.</p> <p>At the time of the survey, there was no evidence the facility ensured that the day program provided Resident #1 with an appropriate place mat for use during her meals, to encourage her to eat in a manner consistent with her developmental level.</p>	I 180	<p>1180 3508.1</p> <p>This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Reference response to W120 for both #1 and #3. 2. Reference response to W159. 3. Reference response to W474. 4. Reference response to W436. 	4.16.10 ongoing

Health Regulation Administration

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I 180	<p>Continued From page 3</p> <p>b. On 3/11/2010, at 12:52 p.m., Staff #1 adjusted Resident #1's seat, so that she sat closer to the table during her lunch. Although the resident was observed to be able to sit in a more upright position, she leaned forward, placing her lower lip against the high sided plate of food as she began to eat. Staff was not observed to prompt the resident to sit upright as she ate. The resident placed large spoonfuls of food in her mouth at a steady pace, until she was almost finished eating her meal. As the resident ate, her plate slid toward her, and from side to side on the table. No mealtime instructions or mealtime feeding protocol (MFP) were observed at the dining table for the resident.</p> <p>Interview with Staff #1 on 3/11/2010, at 1:02 p.m., revealed Resident #1 generally leans over to the plate to eat her food, and eats at a rapid, steady pace because she's a "good eater".</p> <p>On 3/12/2010 at approximately 12:07 p.m., interview with the facility's qualified mental retardation professional (QMRP) revealed the resident has a MFP at the group home, which also should have been implemented by the day program staff. The QMRP acknowledged that she was not aware that the day program was not implementing the MFP as written and that she would immediately work to address the problem.</p> <p>Record review on 3/12/2010 at 12:15 p.m. revealed Resident #1's Mealtime Feeding Protocol (MFP) dated 1/10/2010 recommended the following interventions:</p> <p>(1) Ensure she sits at 90 degrees (2) Allow 1/2 to 1 teaspoonful at a time (3) Allow swallow before presenting another mouthful</p>	I 180	

Health Regulation Administration

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I 180	<p>Continued From page 4</p> <p>(4) Ensure the use of the dycem mat</p> <p>Review of the MFP dated 1/10/2010, revealed the day program failed to ensure the implementation of all four of the interventions listed above during Resident #1's lunch on the afternoon of 3/11/2010.</p> <p>At the time of the survey, there was no evidence the facility ensured Resident #1's MFP was implemented, as written by the day program.</p> <p>2. The QMRP failed to coordinate services to ensure that Resident #3 received continuous active treatment using her voice output box at her day program.</p> <p>Interview with the QMRP on 3/11/2010, at 3:39 p.m., revealed Resident #3 did not take her "Go Talk 4" communication Device to the day program. According to the QMRP, in the past, the day program had implemented the day program speech and language pathologist's objective, which provided training using the Big Mac voice output box. The QMRP, however, was not aware that the use of the Big Mac had been discontinued at the day program after the new Individual Support Plan (ISP) was held on 1/29/2010. Interview with day program case manager and the QMRP on 3/12/2010 revealed that training using the Big Mac voice output device should have been included (continued) in the resident's current day program IPP.</p> <p>On 3/11/2010 at 9:40 a.m., review of the day program's speech and language pathologist's (SLP) communication progress note dated 1/8/2010 revealed, "[Resident #3] actively participates during programming; she is benefiting from the programming that is provided.</p>	I 180	

Health Regulation Administration

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I 180	<p>Continued From page 5</p> <p>Recommendation: She should continue to receive programming to use her voice output device. Vocabulary should be monitored and expanded as needed."</p> <p>At the time of the survey, there was no evidence the the QMRP had coordinated services with the day program to ensure recommendation to enhance Resident #3's communication skills were implemented.</p> <p>3. Observation on the evening of 3/11/2010 at 5:15 p.m. revealed Resident #1 was seated at the dining room table for dinner. Her meal was pureed except for her string beans which were cut into pieces approximately ½ inch to 1 inch long. She was observed bent over with her lips touching the side of the high sided plate of food.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010 at approximately 12:20 p.m. revealed she was not aware the facility's staff had not finely chopped the string beans, as outlined in the MFP and written on her POS. The QMRP indicated she would have staff retrained to address the problem.</p> <p>Record review on 3/12/2010, at approximately 12:22 p.m. revealed Resident #1's Mealtime Feeding Protocol (MFP) dated 1/10/2010 and her physician's order sheets (POS) dated 2/2010 recommended "String beans ... finely chopped". Information provided on her MFP and POS revealed the facility failed to ensure Resident #1's string beans were finely chopped as prescribed during her dinner on the evening of 3/11/2010.</p> <p>Additional interview with the facility's qualified mental retardation professional (QMRP) on</p>	I 180		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2010
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I 180	<p>Continued From page 6</p> <p>3/12/2010 at approximately 12:20 p.m. revealed she was not aware the facility's staff had not finely chopped the string beans as outlined in the MFP and written on her POS. The QMRP indicated she would have staff retrained to address the problem.</p> <p>At the time of the survey, there was no evidence the facility ensured that each food was provided in the texture prescribed by the MFP and the POS.</p> <p>4. The QMRP failed to coordinate with Resident #1's mealtime protocol to ensure it accurate implementation as evidenced below:</p> <p>a. Observation on the evening of 3/11/2010 at 5:15 p.m., revealed Resident #1 was seated at the dining room table for dinner. Her meal was served in a high sided plate, which was placed on a piece of cloth used as a place mat. The piece of cloth measured approximately 12 inches by 12 inches.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010 at approximately 12:22 p.m. acknowledged that staff should have provided Resident #1 with a dycem mat to stabilize the plate, as the resident ate. Further interview with the QMRP revealed she was not aware the residential staff had not provided Resident #1 with her dycem mat, as recommended for use during the meal. The QMRP further indicated she would retrain the staff to address the oversight immediately.</p> <p>Record review on 3/12/2010 at 12:07 p.m. revealed Resident #1's Mealtime Feeding Protocol (MFP) dated 1/10/2010 recommended she be provided a dycem mat during her meals.</p>	I 180		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2010
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I 180	<p>Continued From page 7</p> <p>At the time of the survey, there was no evidence the facility ensured the consistent use of adaptive equipment recommended by the IDT for Resident #1.</p> <p>b. Observation on the evening of 3/11/2010 at 5:15 p.m. revealed Resident #1 was seated at the dining room table for dinner. Her meal was pureed except for her string beans which were cut into pieces approximately 1/2 inch to 1 inch long. She was observed bent over with her lips touching the side of the high sided plate of food.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010 at approximately 12:20 p.m. revealed she was not aware the facility's staff had not finely chopped the string beans, as outlined in the MFP and written on her POS. The QMRP indicated she would have staff retrained to address the problem.</p> <p>Record review on 3/12/2010, at approximately 12:22 p.m. revealed Resident #1's Mealtime Feeding Protocol (MFP) dated 1/10/2010 and her physician's order sheets (POS) dated 2/2010 recommended "String beans ... finely chopped". Information provided on her MFP and POS revealed the facility failed to ensure Resident #1's string beans were finely chopped as prescribed during her dinner on the evening of 3/11/2010.</p> <p>Additional interview with the facility's qualified mental retardation professional (QMRP) on 3/12/2010 at approximately 12:20 p.m. revealed she was not aware the facility's staff had not finely chopped the string beans as outlined in the MFP and written on her POS. The QMRP indicated she would have staff retrained to</p>	I 180		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2010
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I 180	Continued From page 8 address the problem. At the time of the survey, there was no evidence the facility ensured that each food was provided in the texture prescribed by the MFP and the POS.	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 record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure all contracted staff secured an annual health inventory as required by this section. [Consultants #3 and #7] The finding includes: Record review and interview with the GHMRP's qualified mental retardation professional (QMRP) on 3/12/2009 at approximately 10:55 a.m. revealed two out of eight contracted staff did not have a current health inventory on file. Consultant #7's health certificate was not dated and there was no means of validating when it was completed.	I 206	1206 3509.6 Personnel Policies This Statute will be met as evidenced by: Consultant #7 is no longer contracted with the company. Consultant #3 has an updated health inventory on file. Consultant #3 is not the assigned consultant for this location. All consultant health inventories will continue to be monitored and tracked for compliance. Notices will be sent to prior to expiration and documents filed for review.	3/15/10 ongoing
I 226	3510.5(c) STAFF TRAINING	I 226		

PRINTED: 04/07/2010
FORM APPROVED

Health Regulation Administration

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I 226	<p>Continued From page 9</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for three of six residents residing at the home. (Residents #1, #2, and #4)</p> <p>The findings include:</p> <p>1. On March 10, 2010, at approximately 7:00 p.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse her hands prior to administering medications to Resident #4. However, LPN #1 touched the Medication Administration Records (MAR's), medication basket and then touched the rim of Resident #4's medication cup.</p> <p>During a face to face interview with LPN #1 on December 17, 2009, at approximately 6:53 a.m., it was acknowledged after using hand sanitizer to cleanse her hands the LPN #1 touched the MAR's, medication basket and then touched the rim of Resident #4's medication cup.</p> <p>There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>2. On March 10, 2010, at approximately 8:00 p.m., LPN #1 was observed to use hand sanitizer to cleanse her hands prior to administering medications to Resident #3. However, LPN #1 touched the tri-fold examination screen and then</p>	I 226			

PRINTED: 04/07/2010
FORM APPROVED

Health Regulation Administration

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I 226	Continued From page 10 touched the rim of the medication cup Resident #3 used to consume the medications. During a face to face interview with LPN #1 on December 17, 2009, at approximately 6:53 a.m., it was acknowledged that after using hand sanitizer to cleanse her hands, she touched the tri-fold examination screen and then touched the rim of the medication cup Resident #3 used to consume the medications. There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	I 226		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure all staff was trained and certified to perform cardiopulmonary resuscitation (CPR) and First Aid procedures. [Staff #1, #2, #4, #8, #6, #10 and #14] The finding includes: 1. Record review on 3/12/2010 at approximately 11:05 a.m. revealed four out of sixteen employee records reviewed failed to show evidence that a valid CPR certification was obtained and kept on	I 227	1227 3510.5(d) This Statute will be met as evidenced by: 1. The CPR/First Aid records were on file at the time of the survey. (see attached copies). According to the QMRP and Facility Coordinator the survey did not discuss or inquire about CPR/First Aid certifications. The training department will continue to monitor compliance and schedule bi-weekly CPR/First Aid classes for scheduled staff.	3-13-10 ongoing

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Health Regulation Administration

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1227	Continued From page 11 file. [Staff #1, #2, #6 and #10] Interview with the qualified mental retardation professional on 3/12/2010 at approximately 3:30 p.m. revealed she would have to coordinate with the human resources department to resolve the filing error. The GHMRP failed to ensure all staff received training and was certified to perform CPR as required by this section. 2. Record review on 3/12/2010 at approximately 11:45 a.m. revealed three out of sixteen employee records reviewed failed to show evidence that a valid First Aid certification was obtained and kept on file. [Staff #4, #8 and #14] Interview with the qualified mental retardation professional on 3/12/2010 at approximately 3:35 p.m. revealed she would have to coordinate with the human resources department to resolve the filing error. The GHMRP failed to ensure all staff received training and was certified to perform First Aid as required by this section.	1227	2. First Aid certification for one staff is pending receipt of the First Aid card. Attached verification that the staff attended and completed First Aid on 3.10.10. Training department will continue to monitor compliance and schedule bi-weekly CPR/First Aid classes for staff. Cards will be distributed to staff immediately upon receipt.	3-13-10 ongoing

Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018		
(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 122	Continued From page 1 still pending. Interview with the facility's qualified mental retardation professional on 3/12/2010 at approximately 6:00 p.m. revealed the management staff agreed to correct the oversight and enact a plan to ensure all personnel secured a valid criminal background check.	R 122		