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

PRINTED: 02/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G123		02/10/2011

NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 431 53RD STREET, SE, WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from February 9, 2011, through February 10, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five females and one male with various levels of developmental disabilities. A focused review of Client #4's psychotropic medications and behavior support needs was conducted. The findings of the survey were based on observations at the group home, two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000	Received 3/16/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's governing body provided general operating direction, except in the following area: The finding includes: Cross-refer to W170. The governing body failed to ensure that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH	W 104	The Governing Body will ensure the consulting Speech-Language Therapist is licensed per District of Columbia regulations, or will engage a new consultant who is properly licensed per regulation.	2/21/11 On-going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Monica H. Thompson — TITLE: Chief Operating Officer — (X6) DATE: 3/6/2011

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 104	Continued From page 1	W 104		
W 120	PROFESSIONALS 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs, for one of the three clients included in the sample. (Client #3) The finding includes: The day program failed to ensure that Client #3 received fluids in the form consistent with his prescribed dietary needs, as evidenced below: On February 9, 2011, Client #3 was observed receiving his lunch at his day program. At 12:19 p.m., his direct support staff began setting up the client's lunch. Minutes later, the support staff was observed pouring a cup of juice, along with a heaping teaspoon of powdered thickener, into a spout cup. She then sat in front of Client #3 and was about to begin feeding him. At the time, his juice appeared to have a nectar consistency. At approximately 12:24 p.m., interview with the direct support staff indicated that she was not aware of the consistency required for the client's fluids. The medication nurse entered the classroom and directed the staff to review the client's mealtime protocol. After the staff read Client #3's mealtime protocol, she made no changes to the client's juice. The medication nurse then read the mealtime protocol and	W 120	The DON will coordinate with the Day Program Nursing staff to ensure that staff are trained on correct dining protocols, including consistency of food and beverages, for the client. Refresher training was provided to the day program staff. QDDP, RD and facility nurse will continue on-going monitoring of individuals mealtime at the day program to ensure compliance with the feeding protocol as ordered.	3/4/11 On-going

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W 120	Continued From page 2 immediately informed the staff that the client did not require thickened liquids. On February 9, 2011, at approximately 12:45 p.m., review of Client #3's mealtime protocol, dated June 2010, and his physician orders dated December 2010, revealed no order for thickening his liquids. When interviewed a short time later, the day program's registered nurse confirmed that Client #3 should not receive thickener to his liquids Interview with the three residential staff on February 9, 2011, beginning at 2:40 p.m., revealed that Client #3 did not receive thickener to liquids.	W 120		
W 170	483.430(b)(5) PROFESSIONAL PROGRAM SERVICES Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one out of 12 contracted health professionals was licensed, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding includes: Review of the personnel records on February 9, 2011, beginning at 7:00 p.m., revealed that a current license/professional certification was not	W 170	See response to W 104. The Human Resources Director will establish a procedure to periodically audit the records of consultant professionals, to ensure that licenses and other required documents to ensure valid copies are on file.	2/21/11 On-going

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W 170	Continued From page 3 available for the Speech Language Therapist. At approximately 7:35 p.m., the qualified mental retardation professional (QMRP) confirmed that the license/ professional credentialing for the Speech Language Therapist (SLT) was not available for review. On February 10, 2011, at approximately 10:30 a.m., the QMRP stated that she had spoken to the SLT by telephone. The STL reportedly confirmed that she did not have a license issued by the District of Columbia but would proceed with obtaining one. It should be noted that review of Client #3's records on February 10, 2011, at approximately 9:40 a.m., revealed that the consulting STL had performed an annual Speech-Language Evaluation for the client on October 5, 2010. On February 11, 2011, at 12:37 p.m., a post-survey search of professional licensing records online revealed no evidence that the consulting Speech Language Therapist was licensed to practice in the District of Columbia, in accordance with: Title 3, Chapter 12 of the District of Columbia Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling,	W 170		

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W 170	Continued From page 4 audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise provided in this chapter.	W 170		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed towarc clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to manage the provisions outlined in a client's mealtime feeding protocol, for one of three sampled clients. [Client #1] The finding includes: Observations on February 9, 2011, at approximately 7:22 a.m., revealed Client #1 was seated in a recliner in her bedroom while her attending staff fed her breakfast. The chair was placed in the middle of her bedroom and she was positioned at approximately a fifty-five (55) degree angle as she sat during her meal. Further observations on February 9, 2011, at approximately 5:25 p.m., revealed Client #1 was again seated in a recliner in her bedroom while her attending staff fed her dinner. The chair was again observed to be in the middle of her bedroom and she was positioned at approximately a fifty-five (55) degree angle during	W 192	Client #1's wheelchair repair was completed on 2/11/11. The QDDP will retrain all staff, including LPNs, on appropriate positioning protocols for each individual in the home. The training will include dining and post-dining positioning. The DON and DRS will collaborate and produce a plan to monitor performance on this and other health care management and habilitation implementation.	2/11/11 On-going

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W 192	Continued From page 5	W 192		

her meal. The house manager (HM) entered the room at approximately 5:28 p.m. and asked if the chair was positioned "all the way up." She asked this as she reached down and pulled on the lever on the side of the chair. The staff who was feeding Client #1 replied "yes", the chair was positioned. The HM then left the room. The client, however, remained at a reclined position of approximately 55 degrees.

Review of her mealtime feeding protocol on February 10, 2011, at 1:03 p.m., revealed she should be seated at ninety (90) degrees during meals. The mealtime protocol did not list any potential dangers during feeding or indicate a diagnosis of dysphagia, but it addressed Client #1's need for proper positioning while being served her pureed meals. On February 10, 2011, at approximately 11:45 a.m., review of staff in-service training records revealed that they had received training on the mealtime feeding protocol on October 26, 2010 and November 3, 2010. Observations on February 9, 2011, however, indicated that the training had not been effective.

Interview with the facility's QMRP, HM, and direct care staff on February 11, 2011, at approximately 4:10 p.m., revealed Client #1 could be seated upright in the recliner by placing the chair against one of the walls in her bedroom and propping her head with a pillow. The HM, with assistance from staff, pulled Client #1's chair against her closet door and prompted staff to prop Client #1's head with a pillow to get her seated in an upright position. The HM then indicated that this was the method staff employed to ensure Client #1 was being fed her meals while being seated at ninety (90) degrees.

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W 192	Continued From page 6 The facility failed to ensure staff was able to effectively manage the position requirements outlined in Client #1's mealtime feeding protocol.	W 192		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of the six clients residing in the facility. (Client #4) The finding includes: During the entrance conference on February 9, 2011, beginning at 9:13 a.m., interview with the qualified mental retardation professional (QMRP) revealed that Client #4 was the only client in the facility who received psychotropic medications for behavior. Review of Client #4's physician order (POS) dated October 18, 2010, on February 10, 2011, beginning at 11:47 a.m., revealed the following order for sedation: Ativan 2 mg plus Benadryl 500 mg, two hours before X-Ray. Minutes later, review of Client #4's corresponding medication administration record, confirmed that the client had received the aforementioned sedation. Interview with the QMRP on February 10, 2011, at approximately 12:40 p.m., revealed that Client	W 262	The COO is revising the Human Rights Committee Charter, and recruiting additional volunteers as voting members. The Charter will include a provision for emergency reviews, etc., that must take place between scheduled meetings. Further, the COO and DRS will implement a system to document review and approval of restrictive measures, to include written informed consent.	2/17/11 On-going

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W 262	Continued From page 7 #4 received the sedation to address her non-compliance prior to "all" medical appointments. Further interview indicated that the client had a target behavior of medical non-compliance in her behavior support plan (BSP) dated July 31, 2011. This was confirmed moments later through review of her BSP. The QMRP further stated that the HRC discussed the client's BSP (medical non-compliance); however, subsequent review of the minutes taken during HRC meetings during the previous 12-month period revealed no documentation to confirm that the committee had reviewed and/or approved the use of sedation before Client #4's X-Ray.	W 262		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure preventive health services, for one of the three clients in the sample. (Client #1) The finding includes: Cross-refer to W192. On February 9, 2011, the facility's medical team failed to ensure that staff positioned Client #1 in an upright position (90 degrees) during meals, in accordance with the client's Mealtime Protocol, dated September 28, 2010. It should be noted that review of the facility's staffing schedule and interviews with nursing staff and the QMRP revealed that a nurse was assigned on duty at every meal time.	W 322	See response to W192.	2/11/11 On-going
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		

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W 436	Continued From page 8 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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients were able to use the correct adaptive equipment during meals for one of three sampled clients. [Client #1] The finding includes: On February 9, 2011, during the entrance conference, that began at 9:13 a.m., interview with the qualified mental retardation professional (QMRP) revealed that Client #1's custom molded wheelchair was inoperable; therefore, the client was staying home from day program. The wheelchair reportedly had been broken for "approximately 1 week." Later that day, at 5:25 p.m., Client #1 was observed sitting in a large recliner in her room during dinner. Client #1 was seated in a reclining position with a pillow behind her head as the staff fed her a pureed meal. She was reclined to approximately fifty-five (55) degrees as she sat during her meal. The house manager entered the room at approximately 5:28 p.m. and asked if the chair was positioned "all the way up." She asked this as she reached down and pulled on the lever on the side of the chair. The staff who was	W 436	The COO and DRS are addressing the adaptive equipment acquisition and repair needs for clients through the policies and resources available through the DHCF and DDS. The COO will explore all options to effectuate repairs within the timelines included in DDS policy. Client #1's wheelchair part arrived on 2/10/11 and repaired completed on 2/11/11. In addition, review of record show that the home staffs follow up on individual #1's adaptive equipment repair as outlined in the adaptive equipment policies and procedures; such as on-going dialogue with vendor, involvement of DDS SC and continual active treatment within the period that individual was unable to use her wheelchair. The delay in repair was due to parts that were ordered for replacement. QMRP/home manager will complete a periodic audit of Adaptive equipment book to ensure compliance with all equipment repairs as occurs. The COO will establish a tracking protocol to ensure that repairs are requested on time, and that the DDS Service Coordinator is notified in writing of the request; and that each step in the acquisition process that is within the control of the agency takes place on time.	2/11/11 On-going

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W 436	Continued From page 9	W 436		
	feeding Client #1 replied "yes", the chair was positioned. The house manager then left the room The client, however, remained at a reclined position of approximately 55 degrees.			
	Record review on February 10, 2011, at 1:04 p.m., revealed Client #1's Mealtime Protocol, dated September 28, 2010, recommended that the staff "Position [the client] upright at 90 degrees" during meals and to "Adjust harness, if necessary to position upper extremities." Client #1 was not seated at ninety (90) degrees during her meal. The staff was not able to adjust her harness to better position her upper extremities as outlined in the mealtime protocol due to a broken wheelchair. [Note: Review of Client #1's physician's orders and nutrition records revealed no diagnosis of dysphagia or risk of aspiration.]			
	Interview with the facility's QMRP, house manager (HM), and direct care staff on February 10, 2011, at approximately 4:10 p.m., revealed Client #1 could be seated upright in the recliner by placing the chair against one of the walls in the room and propping her head with a pillow. The HM indicated that this was the method being used by the staff to ensure Client #1 was being fed her meals while being seated at ninety (90) degrees. Further interview, however, confirmed that this was not the technique used by the staff during the dinner observations on February 9, 2011.			
	The facility failed to ensure Client #1 was provided with the necessary adaptive equipment (i.e. wheelchair with safety harness) to ensure proper positioning during meals.			
W 474	483.480(b)(2)(iii) MEAL SERVICES	W 474		
	Food must be served in a form consistent with the			

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W 474	Continued From page 10 developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to serve each food in a form consistent with the prescribed texture, for one of the three sampled clients. (Client #3) The finding includes: Cross-refer to W120. The day program failed to ensure that Client #3 received liquids in a form consistent with his prescribed dietary needs.	W 474	See response to W120.	3/4/11 On-going

PRINTED: 02/23/2011
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
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I 000	INITIAL COMMENTS A licensure survey was conducted from February 9, 2011, through February 10, 2011. A random sample of three residents was selected from a population of five females and one male with various levels of developmental disabilities. A focused review of Resident #4's psychotropic medications and behavior support needs was conducted. The findings of the survey were based on observations at the group home, two day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	I 000		
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that outside services met the needs, for one of the three residents included in the sample. (Resident #3) The findings include: The day program failed to ensure that Resident #3 received fluids in the form consistent with his prescribed dietary needs, as evidenced below: On February 9, 2011, Resident #3 was observed receiving his lunch at his day program. At 12:19 p.m., his direct support staff began setting up the	I 047	See response to federal deficiency W120.	3/4/11 On-going

PRINTED: 02/23/2011
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0035		02/10/2011

NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 431 53RD STREET, SE 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 047	Continued From page 1 resident's lunch. Minutes later, the support staff was observed pouring a cup of juice, along with a heaping teaspoon of powdered thickener, into a spout cup. She then sat in front of Resident #3 and was about to begin feeding him. At the time, the juice appeared to have a nectar consistency. At approximately 12:24 p.m., interview with the direct support staff indicated that she was not aware of the consistency required for the resident's fluids. The medication nurse entered the classroom and directed the staff to review the resident's mealtime protocol. After the staff read Resident #3's mealtime protocol, she made no changes to his juice. The medication nurse then read the mealtime protocol and immediately informed the staff that the resident did not require thickened liquids. On February 9, 2011 at approximately 12:45 p.m., review of Client #3's mealtime protocol, dated June 2010, and his physician orders dated December 2010, revealed no order for thickening his liquids. When interviewed a short time later, the day program's registered nurse confirmed that Resident #3 should not receive thickener to his liquids. Interview with the three residential staff on February 9, 2011, beginning at 2:40 p.m., revealed that Resident #3 did not receive thickener to liquids.	I 047		
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.	I 422	See response to federal deficiencies W192 and W436.	2/11/11 On-going

PRINTED: 02/23/2011
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE: 431 53RD STREET, SE WASHINGTON, DC 20019		

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I 422	Continued From page 2 This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that residents received habilitation and assistance as prescribed in their Individual Support Plan, for one of the three residents in the sample. [Resident #1] The finding includes: On February 9, 2011, during the entrance conference, that began at 9:13 a.m., interview with the qualified mental retardation professional (QMRP) revealed that Resident #1's custom molded wheelchair was inoperable; therefore, the resident was staying home from day program. The wheelchair reportedly had been broken for "approximately 1 week." Later that day, at 5:25 p.m., Resident #1 was observed sitting in a large recliner in her room during dinner. Resident #1 was seated in a reclining position with a pillow behind her head as the staff fed her a pureed meal. She was reclined to approximately fifty-five (55) degrees as she sat during her meal. The house manager entered the room at approximately 5:28 p.m. and asked if the chair was positioned "all the way up." She asked this as she reached down and pulled on the lever on the side of the chair. The staff who was feeding Resident #1 replied "yes", the chair was positioned. The house manager then left the room. The resident, however, remained at a reclined position of approximately 55 degrees. Record review on February 10, 2011, at 1:04 p.m., revealed Resident #1's ISP incorporated a Mealtime Protocol, dated September 28, 2010. The Mealtime Protocol instructed staff to	I 422		

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	HFD03-0035		02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	431 53RD STREET, SE WASHINGTON, DC 20019

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I 422	Continued From page 3 "Position [the resident] upright at 90 degrees" during meals and to "Adjust harness, if necessary to position upper extremities." Resident #1 was not seated at ninety (90) degrees during her meal. The staff was not able to adjust her harness to better position her upper extremities as outlined in the mealtime protocol due to a broken wheelchair. [Note: Review of Resident #1's physician's orders and nutrition records revealed no diagnosis of dysphagia or risk of aspiration.] Interview with the QMRP, house manager (HM), and direct care staff on February 10, 2011, at approximately 4:10 p.m., revealed Resident #1 could be seated upright in the recliner by placing the chair against one of the walls in the room and propping her head with a pillow. The HM indicated that this was the method being used by the staff to ensure Resident #1 was being fed her meals while being seated at ninety (90) degrees. Further interview, however, confirmed that this was not the technique used by the staff during the dinner observations on February 9, 2011. The facility failed to ensure Resident #1 was provided with the necessary adaptive equipment (i.e. wheelchair with safety harness) and staff failed to ensure proper positioning during meals.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	I 500	See response to federal deficiency W262.	2/17/11 On-going

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	431 53RD STREET, SE WASHINGTON, DC 20019

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I 500	Continued From page 4 This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of the six residents residing in the facility. (Resident #4) The finding includes: During the entrance conference on February 9, 2011, beginning at 9:13 a.m., interview with the qualified mental retardation professional (QMRP) revealed that Resident #4 was the only resident in the facility who received psychotropic medications for behavior. Review of Resident #4's physician order (POS) dated December 2010, on February 10, 2011, beginning at 11:47 a.m., revealed the following order for sedation: Ativan 2 mg plus Benadryl 500 mg, two hours before X-Ray. Minutes later, review of Resident #4's medication administration record confirmed that the resident had received the aforementioned sedation. Interview with the QMRP on February 10, 2011, at approximately 12:40 p.m., revealed that Resident #4 received the sedation to address her non-compliance prior to "all" medical appointments. Further interview indicated that the resident had a target behavior of medical non-compliance in her behavior support plan (BSP) dated July 31, 2011. This was confirmed moments later through review of her BSP. The QMRP further stated that the HRC discussed the resident's BSP (medical non-compliance); however, subsequent review of the minutes taken during HRC meetings during the previous 12-month period revealed no documentation to confirm that the committee had reviewed and/or approved the use of sedation before Resident	I 500		

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019	

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I 500	Continued From page 5 #4's X-Ray.	I 500		