

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

PRINTED: 02/21/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  C 02/15/2008
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE WASHINGTON, DC 20018
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>The Department of Health/Health Regulation Administration (DOH/HRA) received five unusual incident reports via facsimile on January 4, 7, 23 and 28, 2008 from the facility involving six hospital emergency room visits by residents in January, 2008. At the time of the investigation three of the eight residents residing in the facility had been hospitalized within the month of January, 2008.</p> <p>1. Review of unusual incident reports on February 12, 2008 at approximately 9:40 AM revealed the following:</p> <p>a.) Client #1 was transported to the emergency room on January 4, 2008, for a productive cough that did not respond to medication therapy and was treated and released.</p> <p>b.) Client #1 was transported to the hospital emergency room on January 7, 2008, for a productive cough and admitted to the hospital with a diagnosis of pneumonia. Client #1 was discharged from the hospital on January 10, 2008.</p> <p>c.) Client #1 was transported from the day program to the hospital emergency room on January 23, 2008, for difficulty breathing and admitted to the hospital with a diagnosis of respiratory failure and aspiratory pneumonia. Client # 1 was discharged from the hospital on January 31, 2008.</p> <p>d.) Client #2 was transported to the hospital emergency room on January 6, 2008, because her gastric tube was blocked. Client #2 was treated with a temporary gastric tube replacement</p>	W 000		2008 MAR 10 A 10:38 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marcy March</i>	TITLE <i>ORR</i>	(X6) DATE <i>3-4-08</i>
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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 her 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.

02/21/2008 08:11 FAX 2024428430

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W 000	<p>Continued From page 1 and released.</p> <p>[Note: Client #2's temporary gastric tube was replaced with a permanent gastric tube on January 14, 2008.]</p> <p>e.) Client #3 was transported to the hospital emergency room via 911 on January 28, 2008, for an elevated temperature. Client #3 was admitted to the hospital with a diagnosis of sepsis. At the time of the investigation Client #3 remained in the hospital.</p> <p>f.) Client #4 was transported to the hospital emergency room on January 21, 2008, because he was weak, had diminished bowel sounds in all four quadrants and vomited a blood stained tissue like substance that was approximately three centimeters long. Client #4 was admitted to the hospital for vomiting and was discharged from the hospital on January 28, 2008.</p> <p>[Note: Client #4 was admitted to the hospital on February 8, 2008 for a scheduled right laparoscopic radical nephrectomy and open cystolithotomy. Client #4 was discharged from the hospital on February 12, 2008.]</p> <p>An investigation was conducted February 12-15, 2008 based on the identification of concerns related to the facility's capacity to furnish adequate services for the three males and one female with varying degrees of disabilities that resided in this facility. The investigative findings</p>	W 000			

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W 000	Continued From page 2 were based on observations in the group home and interviews with residential, nursing, and administrative staff. Review of records, including investigations of unusual incident reports was also conducted.	W 000		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for one of four clients in the investigation. (Client # 3)</p> <p>The finding includes:</p> <p>The QMRP failed to obtain a gel mattress as recommended by the Physical Therapist (PT) for Client # 3 as evidenced by:</p> <p>Observation of Client #3's hospital bed on February 14, 2008 at approximately 3:30 PM revealed that there was a foam mattress lying on top of a standard mattress. Review of the PT consult dated October 24, 2007 on February 14, 2008 at approximately 3:50 PM revealed that Client #3 had bilateral spastic quadriparesis and status post coccyx pressure ulcer. Further review revealed a recommendation for a gel mattress for Client #3. Interview with the QMRP on February 14, 2008 at approximately 4:00 PM revealed that the gel mattress had been ordered a "few days ago". There was no evidence that Client #3 had a</p>	W 159	<p><b>W159</b> <b>This Standard will be met as evidenced by:</b></p> <p>As indicated in the report findings the gel mattress for client #3 was on order at the time of the survey. The gel mattress was received on February 17, 2008. QMRP will ensure that all recommendations are followed and addressed in a timely manner. QMRP will review recommendations at least monthly and provide ongoing status reports via "Monthly Progress Note" of the identified recommendations.</p> <p>Routine QA reviews will be conducted to further maintain compliance with this standard.</p>	2-17-08 ongoing

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W 159	Continued From page 3 gel mattress on his hospital bed as recommended by the PT.	W 159			
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.  This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of the four clients included in the investigation. (Client #3)  The findings include:  1. Review of Client #3's physician's orders (POS) dated December 27, 2007, on February 15, 2008 at approximately 2:30 PM revealed an order for the client to have a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on February 15, 2008 at approximately 2:45 PM it was acknowledged that Client #3 did not have the laboratory test performed. There was no evidence that the urinalysis was scheduled or obtained as recommended by the physician.  2. Review of Client #3's POS dated December 27, 2007, on February 15, 2008 at approximately 2:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained. In an interview with the LPN on February 15, 2008 at approximately 2:55 PM it was acknowledged that Client #3 did not have the laboratory test performed. There was no evidence that the urine	W 325			

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W 325	Continued From page 4 for culture and sensitivity was scheduled or obtained as recommended by the physician.	W 325	<p><b>W325</b> <b>This Standard will be met as evidenced by:</b></p> <p>The routine laboratory studies for client #3 were completed as ordered by the Primary Care Physician.</p> <p>An annual laboratory schedule is developed each year following the individual's ISP and updated as ordered by the Primary Care Physician. RN will continue to monitor to ensure that all recommended laboratories studies are completed in a timely manner.</p> <p>RN will conduct additional training as needed.</p>	2-20-08 ongoing

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1000	<p><b>INITIAL COMMENTS</b></p> <p>The Department of Health/Health Regulation Administration (DOH/HRA) received five unusual incident reports via facsimile on January 4, 7, 23 and 28, 2008, involving six hospital emergency room visits in January, 2008. At the time of the investigation three of the eight residents residing in the facility had been hospitalized within the month of January, 2008.</p> <p>1. Review of unusual incident reports on February 12, 2008 at approximately 9:40 AM revealed the following:</p> <p>a.) Resident #1 was transported to the emergency room on January 4, 2008, for a productive cough that did not respond to medication therapy and was treated and released.</p> <p>b.) Resident #1 was transported to the hospital emergency room on January 7, 2008, for a productive cough and admitted to the hospital with a diagnosis of Pneumonia. Resident #1 was discharged from the hospital on January 10, 2008.</p> <p>c.) Resident #1 was transported to the hospital emergency room on January 23, 2008, from the day program for a productive cough and admitted to the hospital with a diagnosis of Respiratory Failure and Aspiratory Pneumonia. Resident # 1 was discharged from the hospital on January 31, 2008.</p> <p>d.) Resident #2 was transported to the hospital</p>	1000		

Health Regulation Administration

*Maria March*

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

TITLE  
*DRS*

(X6) DATE  
*2.28.08*

STATE FORM

6804

9XMS11

If continuation sheet 1 of 5

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1 000	<p>Continued From page 1</p> <p>emergency room on January 8, 2008, because her gastric tube was blocked. Resident #2 was treated and released with a temporary gastric tube.</p> <p>[Note: Client #2's temporary gastric tube was replaced with a permanent gastric tube on January 14, 2008.]</p> <p>e.) Resident #3 was transported to the hospital emergency room via 911 on January 28, 2008, for an elevated temperature. Resident #3 was admitted to the hospital with a diagnosis of sepsis. At the time of the investigation Resident #3 remained in the hospital.</p> <p>f.) Resident #4 was transported to the hospital emergency room on January 21, 2008, because he was weak, had diminished bowel sounds in all four quadrants and vomited a blood stained tissue like substance that was approximately three centimeters long. Resident #4 was admitted to the hospital for vomiting and was discharged from the hospital on January 28, 2008.</p> <p>[Note: Resident #4 was admitted to the hospital on February 8, 2008 for a scheduled right laparoscopic radical nephrectomy and cystolithotomy. Resident #4 was discharged from the hospital on February 12, 2008.]</p> <p>An investigation was conducted February 12-15,</p>	1 000		

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1 000	Continued From page 2  2008 based on the identification of concerns related to the facility's capacity to furnish adequate services for the three males and one female with varying degrees of disabilities that reside in this facility. The investigative findings are based on observations in the group home and interviews with residential, nursing, and administrative staff. Review of records, including investigations of unusual incident reports was also conducted.	1 000		
1 395	3620.2(e) PROFESSION SERVICES: GENERAL PROVISIONS  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:  (e) Nursing;  This Statute is not met as evidenced by: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team for one of four residents in the investigation. ( Resident #3 )  The findings include:	1 395		

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1395	Continued From page 3  1. Review of Resident #3's physician's orders (POS) dated December 27, 2007, on February 16, 2008 at approximately 2:30 PM revealed an order for the client to a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on February 15, 2008 at approximately 2:45 PM it was acknowledged that Resident #3 did not have the laboratory test performed. There was no evidence that the urinalysis was scheduled or obtained as recommended by the physician.  2. Review of Resident #3's POS dated December 27, 2007, on February 15, 2008 at approximately 2:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained. In an interview with the LPN on February 15, 2008 at approximately 2:55 PM it was acknowledged that Resident #3 did not have the laboratory test performed. There was no evidence that the urine for culture and sensitivity was scheduled or obtained as recommended by the physician.	1395	Reference response to W325 of the Federal Deficiency report.	2-20-08 ongoing
1422	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 interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided for one of four residents in the investigation in accordance with their Individual Habilitation Plan (IHP). (Resident #3)  The finding includes:  The QMRP failed to obtain a gel mattress as recommended by the Physical Therapist (PT) for	1422	Reference Response to W159 of the Federal Deficiency report.	2-17-08 ongoing

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1422	Continued From page 4 Resident # 3 as evidenced by:  Observation of Resident #3's hospital bed on February 14, 2008 at approximately 3:30 PM revealed that there was a foam mattress overlay on top of a standard mattress. Review of the PT consult dated October 24, 2007 on February 14, 2008 at approximately 3:50 PM revealed that Resident #3 had bilateral spastic quadriparesis and status post coccyx pressure ulcer. Further review revealed a recommendation for a gel mattress for Resident #3. Interview with the QMRP on February 14, 2008 at approximately 4:00 PM revealed that the gel mattress had been ordered a "few days ago". There was no evidence that Resident #3 had a gel mattress on his hospital bed as recommended by the PT.	1422			