

PRINTED: 10/20/2009
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: 08G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4315 EOBSON PLACE, NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG W 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG W 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted on September 30, 2009 through October 5, 2009. The survey was initiated as a full survey due to the facility's history of condition level deficiencies during previous survey periods. A random sampling of four clients from the residential population of five females and two males was selected for the survey. The results of the survey was based on observations in the home and at three day programs. Administrative, nursing and direct care staff interviews were conducted, as well as a review of clients' and administrative records, including a review of the unusual incident reports.</p> <p>Based on the initial findings of the survey, on September 30 2009 at 9:45 p.m., it was determined that nursing practice posed an immediate and serious threat to client's residing in the facility. The agency's Administrator and the facility's Assistant Director/Acting Qualified Mental Retardation Professional (AQMRP) were informed at 11:33 p.m. of the immediate jeopardy to client's health and safety.</p> <p>On October 1, 2009, at approximately 1:25 a.m. the facility's President, Director of Residential Services (DRS), and Assistant Director faxed to the State Agency (SA) a plan of correction to address the immediate jeopardy. The following was the plan submitted by the facility that outlined the proposed corrective measures:</p> <p>1. Medication Pass/Administration/Error-Best Practices, including how to discard medication and what to do if there is spillage or a waste during medication administration;</p>		<p><i>Received 11/13/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				
				
DATE 11/13/09				

Any deficiency statement ending with a asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (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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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4615 EDDON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p>Continued From page 1</p> <p>2. Infection Control-Best Practices, hygiene and medication policies and procedures;</p> <p>3. The Nurse was immediately relieved of duty and removed from the home;</p> <p>4. The Nurse was advised to report to the Operations office in the morning to meet with the Director of Human Resources for further personnel action;</p> <p>5. In-service training will be conducted for all nurses on the hospital discharge policy, adherence to recommendations and follow up with primary care physician;</p> <p>6. All nurses in the home will receive additional training on documentation and communication between primary care physician, nurses and staff post hospitalization/emergency room visit; and</p> <p>7. Improve coordination and communication between ATS staff and nurses during medication administration and routine ADL/Hygiene care.</p> <p>The aforementioned Plan of Correction was not accepted by the State Agency on October 1, 2009 and the Governing Body was informed that nursing competencies must be documented and observed. On October 13, 2009 the facility submitted a second Plan of Correction that outlined the proposed corrective measures:</p> <p>1. The facility conducted training to include by not limited to adherence to mealtime protocols, medication administration, G-tube feedings, transcriptions of physician orders, weights, fluid intake and adherence to fluid restrictions, and interim physician orders;</p>	W 000			

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
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W 000	<p>Continued From page 2</p> <p>2. The Director of Nursing (DON) conducted competency reviews for Licensed Practical Nursing (LPN) assigned to the group home site;</p> <p>3. Policies related to weights, G-tube feedings, and transcriptions will be modified and changed to reflect needs of the individuals served;</p> <p>4. Appropriate disciplinary action was taken to address the LPN and RN's who failed to adhere to standard nursing practices and the facility's policies;</p> <p>5. The Medical Director was employed to oversee, coordinate, and implement effective policies to govern and manage the health care services of the people served;</p> <p>6. The DON will direct and deploy RN supervisors to provide necessary oversight and monitoring; and</p> <p>7. The DON will also provide additional training and oversight for the RN's to further ensure ongoing compliance with the standards set forth.</p> <p>On October 7, 2009, during the course of the survey, the State Agency received a complaint from University Legal (UL) that alleged numerous deficient practices at a day program where three of the clients attend. The complaint alleged numerous deficient practices regarding the coordination of services with three of the clients' day program. Two of the three clients had not been included in the original sample. They were added, however, for focused review of the concerns identified in the complaint. Surveyors visited the day program on October 9, 2009 to</p>	W 000			

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W 000	Continued From page 3 determine compliance with federal and State regulations.	W 000			
W 102	As a result of the findings during the survey and investigation, the facility was determined to be in non-compliance with the Conditions of Participation in the areas of Governing Body, Client Protections, and Health Care Services. 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	W102 This CONDITION will be met as evidenced by: Reference response to W104	11/6/09 On-going	
W 104	This CONDITION is not met as evidenced by: Based on observation, interview and record review the facility's governing body failed to maintain general operating direction over the facility. [See 104]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure each client's health and safety. [See also W318] 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 observation, interview, and record review, the facility's governing body failed to provide general operating directions as evidenced below:	W 104			

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W 000	<p>Continued From page 2</p> <p>2. The Director of Nursing (DON) conducted competency reviews for Licensed Practical Nursing (LPN) assigned to the group home site;</p> <p>3. Policies related to weights, G-tube feedings, and transcriptions will be modified and changed to reflect needs of the individuals served;</p> <p>4. Appropriate disciplinary action was taken to address the LPN and RN's who failed to adhere to standard nursing practices and the facility's policies;</p> <p>5. The Medical Director was employed to oversee, coordinate, and implement effective policies to govern and manage the health care services of the people served;</p> <p>6. The DON will direct and deploy RN supervisors to provide necessary oversight and monitoring; and</p> <p>7. The DON will also provide additional training and oversight for the RN's to further ensure ongoing compliance with the standards set forth.</p> <p>On October 7, 2009, during the course of the survey, the State Agency received a complaint from University Legal (UL) that alleged numerous deficient practices at a day program where three of the clients attend. The complaint alleged numerous deficient practices regarding the coordination of services with three of the clients' day program. Two of the three clients had not been included in the original sample. They were added, however, for focused review of the concerns identified in the complaint. Surveyors visited the day program on October 9, 2009 to</p>	W 000		

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W 000	Continued From page 3 determine compliance with federal and State regulations.	W 000		
W 102	As a result of the findings during the survey and investigation, the facility was determined to be in non-compliance with the Conditions of Participation in the areas of Governing Body, Client Protections, and Health Care Services. 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	W102 This CONDITION will be met as evidenced by: Reference response to W104	11/6/09 On-going
W 104	This CONDITION is not met as evidenced by: Based on observation, interview and record review the facility's governing body failed to maintain general operating direction over the facility. (See 104). The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure each client's health and safety. [See also W312] 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 observation, interview, and record review, the facility's governing body failed to provide general operating directions as evidenced below:	W 104		

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W 104	<p>Continued From page 4</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to ensure the proper documentation of nursing competency. (See W192) 2. The governing body failed to enact policies and/or procedures to ensure the theft of Client #3's television was effectively addressed as identified below: <p>On October 1, 2009 at 10:39 a.m., the review of an unusual incident report dated August 15, 2009 revealed a theft of Client #3's "large flat screen TV. A note on the incident report which was written by the facility's former Qualified Mental Retardation Professional (QMRP) revealed she checked the entire facility and stock rooms on August 17, 2009 in search of the client's television, however did not find it. The incident report documented that the administrator was notified of the incident on August 15, 2009. Further review of the incident report revealed the QMRP spoke with staff who worked on the night of August 14, 2009, to initiate an investigation.</p> <p>Interview with the interim QMRP on October 1, 2009 at 10:50 a.m., revealed she was not working at the group home during the time the incident occurred. The QMRP stated, however, that it was the agency's policy to investigate such incidents. The QMRP stated that since the client's TV had never been located after the incident, the agency should reimburse her for the value of the TV.</p> <p>At the time of the survey, there was no evidence a policy was in place to address the replacement or reimbursement of a client's personal</p>	W 104	<p>W104</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Governing Body will implement nurse competency requirements as measured by written and/or demonstrated-based tests developed by IDI and approved by DDS Training Department. The competency tools will assist in the evaluation and assessment of proficiency of nursing personnel regarding the delivery of health care services and treatment. The RN's competencies will correlate with Standards of Practice within the scope of ANA and AAMR. The program will require that at the time of hire and in designated intervals thereafter each applicant/employee must demonstrate identified competency in key areas to include but not limited to; dietetic services, timely following up medical appointments, infection control, medication administration and charting. 	11/6/09 On-going
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W 104 W 120	<p>Continued From page 5</p> <p>belongings in the event of theft.</p> <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 effectively monitor each client's day program to ensure that their meal time feeding programs were implemented for two of the four clients in the sample. [Clients #3 and #4])</p> <p>The findings include:</p> <p>Based on information obtained during the pre-survey review, this facility was found to be deficient in ensuring client's dietary/fluid intake restrictions. During the survey the following deficient practices were identified:</p> <p>1. Observation at the day program on October 1, 2009 at approximately 10:46 a.m. revealed Client #3 was provided a serving of applesauce and a beverage in a spout cup. Client #3's spout cup was observed to be "half" full. By the end of the feeding, Client #3 had consumed all of the applesauce and juice. Interview with the attending staff revealed, she was trained to fill the spout cup "half way" with whatever beverage she was serving Client #3. Further observation revealed the spout cup did not have any measurement markings on it and there was no measuring device available to the staff to ensure 120cc of fluid was served at the time of the observation. The staff was also asked to inspect</p>	W 104 W 120	<p>W104 Continued...</p> <p>glucose monitoring, seizures monitoring and transcription of orders in order to remain in good standing. Additional Resources will be used as needed and recommended.</p> <p>The Director of Nursing and Training Director will maintain records of competency tests and curriculums.</p> <p>Also reference response to W192</p> <p>2. The Governing body will update policies and procedures to address the replacement or Reimbursement of client's personal belongings in the event of theft. Client #3's television has been replaced. The governing body will ensure that all employees receive additional training on policies and procedures addressing theft of individual funds.</p>	10/30/09 On-going
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WV 120 Continued From page 6
the spout cup to see if there were any measuring marks on it. The staff verified that the spout cup did not have any measuring marks on it and there was no measuring device available for use as well.

Record review on October 2, 2009 at approximately 5:58 p.m. revealed on August 29, 2009, the nurse at Client #3's home received a telephone order from the Primary Care Physician (PCP) which read, "D/C (discontinue) 1200cc fluid restriction, New Order - 1000cc/Day fluid restriction." In addition, Client #3's Mealtime Protocol dated September 3, 2009 reflected she was on a fluid restriction of "1000cc/day". The protocol required her to receive "1/2 Cup (120cc)" of a beverage for her AM snack and "1/2 cup (120cc)" of a beverage for lunch.

The facility failed to ensure Client #3 received her fluids as ordered and failed to ensure outside staff was effectively trained in the implementation and management of Client #3's Mealtime Protocol, to include accurately measuring 120cc of fluids.

2. Interview with the day program staff and record review at Client #4's Day Program on October 1, 2009 at approximately 1:09 p.m. revealed Client #4's current Physician's Orders (POS) dated September 1, 2009 prescribed "Diabetic Boost - 237ml PO at 7:00 a.m., 12:00 p.m., 2:00 p.m., after dinner, and 8:00 p.m. for supplement."

Interview with the day program staff and record review on October 1, 2009 at approximately 1:15 p.m. validated Client #4 does receive his two servings of the Diabetic Boost at the day

W120

W120, Continued...

W120
This Standard will be met as evidenced by:

- Client #3's mealtime protocol has been updated to reflect her current diet order of fluid restriction 1000cc/day. A measuring cup and markings on the cup have been provided to the day program staff. Training was also completed at the day program on fluid restriction requirements for client #3. The QMRP/LPN/RN's will routinely visit the day program (at least twice per month) to monitor implementation of program interventions.

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W 120	Continued From page 7 program. Although the day program staff indicated the client received two cans of the Diabetic Boost at the day program, there was no documentation that the Diabetic Boost was administered/served. (Cross Reference W331)	W 120	2. Additional training was conducted at client #4's day program on documentation and implementation of his Diabetic Boost; supplement. The QMRP/LPN/RN will ensure day program sends documentation of client #4's Boost to his home on monthly basis which will be maintained on file for review. The QMRP/Home Manager/LPN/RN will also routinely conduct follow up monitoring at the day program to ensure compliance with client #4's receiving his Boost as outlined. Cross reference responses to W331. W122 This CONDITION will be met as evidenced by: Cross reference responses to W130 Cross reference W140	11/9/09 On-going
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W 122		
W 130	This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client's right to privacy [See W130]; and failed to ensure a complete and accurate accounting of client's funds during a vacation [See W140]. 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each client's right to privacy, for two of the seven clients residing in the facility (Clients #3 and #6) included in the sample. The finding includes: Observation of the medication administration on September 30, 2009, beginning at approximately 7:16 p.m. revealed Client's #3 and #6 received their medications in their bedrooms. Client #3 had just finished receiving a shower and was	W 130		

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W 130	<p>Continued From page 8</p> <p>observed sitting in a shower chair naked with a bath towel draped over the front of her. During the administration of the medication, a male staff was observed to enter the client's bedroom, without knocking first.</p> <p>Interview with the Assistant Director/Acting Qualified Mental Retardation (AQMRP) on October 5, 2009, at approximately 6:00 p.m. revealed that the staff had been trained to knock on the client's door before entering their rooms.</p> <p>At the time of the survey, the facility failed to ensure Clients #3 and #6 were provided privacy during personal care.</p>	W 130	<p>W130</p> <p>This Standard will be met as evidenced by:</p> <p>All staff will adhere to standards of practice and policies which ensure privacy of individuals during treatment and care. All staff will receive additional training on the individual rights to privacy and closely monitored by the Managers and Nursing staff to ensure ongoing compliance.</p> <p>Additional corrective actions will be taken as necessary to maintain compliance with this standard.</p>	11/6/09 On-going
W 140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a complete and accurate accounting of client's funds for three of the four sampled clients. (Client's #2, #3 and #4)</p> <p>The findings include:</p> <p>Record review and interview with the facility's Acting Qualified Mental Retardation Professional (AQMRP) and House Manager (HM) revealed the facility failed to ensure an effective system of monitoring and managing clients' funds.</p> <p>1. Staff interview and record review on October 1, 2009 at approximately 4:44 p.m., revealed</p>	W 140		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 098119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 WILSON PLACE, NE WASHINGTON, DC 20019
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(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)	PSR COMPLETION DATE
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W 140

Continued From page 9.

Client #2's bank statements reflected withdrawals totaling \$950.09. The following withdrawals were documented between the dates of January 1, 2009 and June 30, 2009 as identified below:

- a. \$160.00 withdrawn on 01/28/2009
- b. \$200.00 withdrawn on 03/12/2009
- c. \$100.90 withdrawn on 03/24/2009
- d. \$500.00 withdrawn on 06/15/2009

Although \$950.09 was withdrawn, only \$182.57 in receipts were available for review. The expenditures are listed below:

- a. 04/08/09 "Clothing" = \$21.29
- b. 03/31/09 "Beauty Supply" = \$21.28
- c. 03/28/09 "Hair Braiding" = \$160.00

The difference of \$757.62 was unaccounted for at the time of survey. There was no documented evidence or receipts on file to substantiate what happened to the remaining funds.

2. Staff interview and record review on October 1, 2009 at approximately 4:15 p.m., revealed Client #3's bank statements reflected withdrawals totaling \$4,163.78. The following withdrawals were documented between the dates of March 1, 2009 and July 31, 2009 as identified below:

- a. \$1,127.00 withdrawn on 03/12/09
- b. \$90.00 withdrawn on 3/24/09
- c. \$2,000.00 withdrawn on 05/08/09
- d. \$446.78 withdrawn on 06/05/2009
- e. \$500.00 withdrawn on 06/15/2009

Although \$4,163.78 was withdrawn, only \$2,983.71 in receipts were available for review. The expenditures are listed below:

W 140

W140

This Standard will be met as evidenced by:

1. Review of the individual financial records shows that all receipts were filed in the client #2,3, and 4's book. However, the former QMRP's documentation and record keeping was inconsistent with procedures and protocols, thus, making it difficult to track and follow. All financial records are now set-up and information has been filed to include accurate and complete accounting of all individual funds. QMRP to be assigned to the home will receive training on policies and procedures regarding client funds and record keeping. The Home Manager will be responsible for conducting monthly audits of the financial records and reconciling all records by the end of each month. The QMRP will be responsible for reviewing and compliance. Governing Body will conduct routine audits to further ensure compliance with this standard.

10/30/09
On-going

0003/0014

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4818 EDSON PLACE, NE WASHINGTON, DC 20019
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W 140 Continued From page 10

a. No Date: "Department Store" = \$747.80
 b. 03/28/2009 "Wholesale Club" = \$242.00
 c. 05/13/2009 "Massage Parlor" = \$1,830.00
 d. 04/01/2009 "Department Store" = \$65.02
 e. 05/06/2009 "Discount Store" = \$28.50
 f. 06/17/2009 "Clothing" = \$49.98
 g. 07/01/2009 "Department Store" = \$67.84
 h. 07/01/2009 "Department Store" = \$41.34
 i. 07/26/2009 "Hair Braiding" = \$50.00
 j. No Date: "Department Store" = \$162.83

The difference of \$1,180.07 was unaccounted for at the time of survey. There was no documented evidence or receipts on file to substantiate what happened to the remaining funds.

3. Staff interview and record review on October 1, 2009 at approximately 4:55 p.m. revealed Client #4's bank statements reflect \$200 was withdrawn on June 15, 2009. Further record review revealed there were no receipts on record at the facility during the time of survey to validate the withdrawal.

Interview with the Acting QMRP and HM on October 2, 2009 at 10:21 a.m. revealed they were also having difficulty following the record keeping for the finances.

W 140

2. Reference response to #1. Review of record shows that client #3 was recommended for a Spend down. All receipts are currently filed in the client book. Reconciliation of client #3's account has been completed and no missing receipts or outstanding funds were discovered. The inappropriate filling of documents by the former QMRP contributed to the confusion and misperception of inaccurate accounting.

3. Reference response to 1 and 2.

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to investigate a theft for

W 154

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W 154

Continued From page 11
one of five sampled clients. (Client #3)

The finding includes:

On October 1, 2009 at 10:39 a.m., the review of an unusual incident report dated August 15, 2009 revealed a theft of Client #3's "large flat screen TV". A note on the incident report which was written by the facility's former Qualified Mental Retardation Professional (QMRP) revealed she had checked the entire facility and stock rooms on August 17, 2009 in search of the client's television, however did not find it.

The incident report documented that the administrator was notified of the incident on August 15, 2009. Further review of the incident report revealed the QMRP spoke with staff who worked on the night of August 14, 2009, to initiate an investigation.

Interview with the Interim QMRP on October 1, 2009 at 10:50 a.m., revealed she was not working at the group home during the time the incident occurred. The QMRP stated, however, that it was the agency's policy to investigate such incidents.

The QMRP contacted the administrative office to obtain a copy of the internal investigation of the incident. Interview with the QMRP on October 5, 2009, revealed that the administrative office did not provide the internal investigation of the incident to her during the survey.

At the time of the survey, there was no evidence a comprehensive investigation of the incident had been conducted.

W 159

482.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 154

W154
This Standard will be met as evidenced by:

The investigation report has been completed on the theft of client #3's television. The incident tracking and monitoring process has been revised to ensure timely receipt of all incident investigation reports. All incoming QMRP's will receive training at the time of hire and ongoing thereafter and/or as needed to further enforce these standards. Copies of the documents will be filed in the Incident Book for review.

Routine QA monitoring will also be conducted and all concerns addressed accordingly.

11/9/09
On-going

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X7) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4615 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETION DATE	
W 159	<p>Continued From page 12</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 staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for three of seven clients residing in the facility. (Client's #3, #4, and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation on October 1, 2009 at approximately 7:15 p.m. revealed Client #4 was served his meal in a pureed texture. At the close of his meal, his attending staff served him a can of "Boost". He consumed the "Boost" by using a straw. A small amount of spillage was observed as he drank the Boost. <p>Record review on 10/2/2009 at 10:02 a.m., revealed Client #4's Third Quarterly Nutrition Review dated 5/5/2009, recommended that the Nutritionist "consult with Speech Therapist to consider thickened liquids, since he has a history of coughing after (consuming) thin liquids." Further record review revealed Client #4 received "Boost Glucose Control [four] times a day at 7am, 12noon, 2pm, after dinner."</p> <p>Interview with the Acting QMRP on 10/2/2009 at 1:27 p.m. revealed, there was no documentation on file to substantiate the Speech Pathologist and the Nutritionist met to address the possibility</p>	W 159	<p>W159 This Standard will be met as evidenced by:</p> <p>The Speech Pathologist has completed a bedside monitoring of client #4's mealtime observation including fluid intake and her findings were reviewed with the Nutritionist. The QMRP will discuss and implement the recommendations as indicated by the IDT. Staff will receive training on client #4's liquid consistency and LPN will monitor daily implementation. Information related to team discussions and decisions will be filed in client #4's book for review.</p> <ol style="list-style-type: none"> 2. Cross Reference W120 3. Cross Reference W249 4. Cross reference W252 5. Cross Reference W257 6. Cross Reference W130 7. Cross reference W189 	11/6/09 On-going	

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W 159	<p>Continued From page 19 adding a thickener to all of Client #4's liquids.</p> <p>The facility's QMRP failed to ensure the coordination of services to assess viable alternatives to potentially improve the care, health and safety of a client as recommended by the Nutritionist.</p> <p>2. The QMRP failed to ensure the coordination of services with an outside vendor with regards to the serving and documenting Client #4's Diabetic Boost. (See W120).</p> <p>3. The QMRP failed to ensure the correct and consistent implementation of Client #4's Individual Program Plan (IPP). (See W249)</p> <p>4. The QMRP failed to ensure the staff accurately implemented and documented Client #4's progress with regards to their Individualized Program Plans. (See W252)</p> <p>5. The QMRP failed to ensure the monitoring and revision of Client #4's Individual Program Plan (IPP) when the client failed to show progress. (See W257)</p> <p>6. The QMRP failed to ensure Client #3 and #6's right to privacy during the administration of medication. (See W130).</p> <p>7. The QMRP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. (See W189)</p>	W 159		
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training</p>	W 192		

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W 192	<p>Continued From page 14 must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for four of seven clients (Client's #2 #3, #4 and #6) residing in the facility.</p> <p>The findings include:</p> <p>The facility's nursing services failed to ensure staff were adequately trained to implement Client #2's discharge orders as evidenced below:</p> <ol style="list-style-type: none"> 1. Observations on September 30, 2009 at 2:02 p.m. revealed Client #2 in her wheelchair seated at the dining room table eating her lunch. Interview with the Assistant Director/Acting Qualified Mental Retardation Professional, (QMRP) on the aforementioned date at 2:07 p.m. revealed that the client had just been discharged that morning from the hospital. Interview with the direct care staff and continued observation revealed the client was eating baked chicken, potato salad and string beans. Additionally, she was given a cup of light cranberry juice. Client #2's food was observed to be served bite sized. <p>Review of the client's discharge summary from the emergency room revealed that the client was diagnosed with dehydration, fecal impaction, and nausea and vomiting. The aftercare instructions for nausea, vomiting, and diarrhea revealed that "It is important to rest the stomach and intestines</p>	W 192	<p>W192 This Standard will be met as evidenced by:</p> <p>All nurses have received training on hospital discharge policy and adherence to recommendations. The RN will monitor, assess and provide instruction and supervision for all LPN staff</p> <ol style="list-style-type: none"> 2. Cross reference W130 3. Cross reference W369 4. Cross reference W375 5. Cross reference W340 	10/30/09 On-going
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 096119	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 10/05/2009
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W 192	<p>Continued From page 16</p> <p>and replace lost build." Continued review of the document revealed the following instruction: "Do not eat solid foods for at least 24 hours." The LPN on duty failed to provide the direct care staff with instructions to address the ER recommendation.</p> <p>Review of the on duty Licensed Practical Nurse's (LPN) orientation training record on October 5, 2009, revealed that the LPN had been trained on "Hospitalization Discharge Orders" on July 23, 2009.</p> <p>At the time of the survey, the facility failed to ensure the nursing staff had been effectively trained to review and implement "hospitalization discharge orders." [See W331.1]</p> <p>2. [Cross Refer to W130]. The facility failed to ensure nursing staff had been trained in providing privacy during the administration of medications for Clients #3 and #6.</p> <p>3. [Cross Refer to W369]. Review of the facility's nursing training on October 5, 2009 revealed the LPN was trained on the facility's Medication Administration Protocol on July 23, 2009. At the time of the survey, the facility failed to ensure nursing staff had been effectively trained to review the client's physician's orders before administering their medications.</p> <p>4. [Cross Refer to W375]. The facility failed to ensure nursing staff had been trained to ensure that drug administration errors were recorded for (Client's #2 and #4).</p> <p>5. [Cross refer to W340]. Client #6's day program staff had not received training on the</p>	W 192		
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W 192	Continued From page 16 client's diagnostic profile, health risks and Health Management Care Plan. Client #3's day program staff had not received training on implementation of the client's fluid restriction.	W 192		
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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the correct and consistent implementation of a client Individual Program Plan (IPP) as recommended for one of four sampled clients. [Client #4] The finding includes: Observation on the evening of October 2, 2009 at approximately 6:00 p.m., revealed Client #4's attending staff wiped his mouth during dinner. Record review on October 5, 2009 at 9:29 a.m., revealed Client #4's had a Social Etiquette program to "wipe his mouth during meals with 50% HOH assistance for six consecutive months by 3/09". Observation during dinner failed to show staff implementing "hand over hand" assistance as required.	W 249	W249 This Standard will be met as evidenced by: Review of record showed that the "wipe mouth" program objective for client #4 was discontinued at the time of his ISP on 9/25/09 as client #4 met potential at hand over hand assistance. Client #4 has a new objective to participate in interactive activities. The QMRP will in-service staff on encouraging client #4 to wipe his mouth during meals as an on going service. In addition, QMRP will also retrain all staff on program documentation and implementation. QMRP and Home Manager will conduct routine monitoring to compliance with documentation standards as set forth.	10/30/09 On-going

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W 249	Continued From page 17 Interview with the Acting Qualified Mental Retardation Professional (AQMRP) and further record review on the same day at approximately 10:32 a.m., confirmed the facility failed to implement Client #4's IPP as written.	W 249			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the accurate documentation of a client's progress on an approved habilitation plan for one of four sampled clients. [Client #4] The finding includes: Observation on the evening of October 2, 2009 at approximately 8:00 p.m., revealed Client #4's attending staff wiped his mouth during dinner. Record review on October 5, 2009 at 9:29 a.m., revealed Client #4's had a Social Etiquette program to "wipe his mouth during meals with 80% HOH assistance for six consecutive months by 3/09". Observation during dinner failed to show staff implementing "hand over hand" assistance as required. Interview with the Acting Qualified Mental Retardation Professional (AQMRP) and further record review on the same day at approximately	W 252	W252 This Standard will be met as evidenced by: Reference response to W249 W257 This Standard will be met as evidenced by: The QMRP will actively monitor individual programs and make timely modifications as needed. QMRP efforts will be documented in the monthly progress notes for review.	10/30/09 On-going	

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4845 EDSON PLACE, RE WASHINGTON, DC 20019		
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W 252	Continued From page 18 10:32 a.m., revealed the following documentation errors: 1. November 2008 - seven (7) days of documentation was missing. 2. October 2008 - eighteen (18) days of documentation was missing. 3. January 2009 - one (1) day of documentation was missing. 4. March 2009 - fourteen (14) days of documentation was missing. 5. June 2009 - nine (9) days of documentation was missing. 6. August 2008 - seven (7) days of documentation was missing.	W 252			
W 257	The facility failed to accurately document Client #4's progress as required by the IPP. 483.440(f)(1)(II) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to revise a client's programming goals and objectives after failing to show progress for one of four sampled clients. [Client #4] The finding includes: Observation on the evening of October 2, 2009 at	W 257	W257 This Standard will be met as evidenced by: The QMRP will actively monitor individual programs and make timely modifications as needed. QMRP efforts will be documented in the monthly progress notes for review.	11/6/09 On-going	

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W 257 Continued From page 19
approximately 6:00 p.m., revealed Client #4's attending staff wiped his mouth during dinner. Record review on October 6, 2009 at 9:29 a.m., revealed Client #4's had a Social Etiquette program to "wipe his mouth during meals with 80% HOH assistance for six consecutive months by 3/09".

Observation during dinner failed to show staff implementing "hand over hand" assistance as required.

Interview with the Acting Qualified Mental Retardation Professional (AQMRP) and further record review on the same day at approximately 10:32 a.m. revealed data for the months of October 2008, November 2008, December 2008, January 2009, February 2009, March 2009, April 2009, May 2009, June 2009, July 2009, and August 2009 revealed he performed the task in the "hand of hand" range on over 90% of all recorded trials. There was no evidence this program was reviewed and/or assessed for revisions or modifications over that time period.

The facility failed to effectively monitor and revise Client #4's programmatic objectives despite his lack of recorded progress.

W 257

W 318 483.460 HEALTH CARE SERVICES

The facility must ensure that specific health care services requirements are met.

This CONDITION is not met as evidenced by:
Based on interviews, and record verification, the facility failed to ensure preventive health services were coordinated [Refer to W322]; the facility's

W 318

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4916 EDSON PLACE, NE WASHINGTON, DC 20019
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(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 318	<p>Continued From page 20</p> <p>nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; the facility's nursing staff failed to provide recommended training to day program staff [Refer to W340]; the facility failed to ensure that drug regimen reviews were conducted at least quarterly [Refer to W362]; the facility failed to ensure their system for drug administration assured that all drugs are administered without error [Refer to W369]; the facility failed to ensure that drug administration errors were recorded [W375]; and the facility failed to notify the primary care physician immediately of all drug administration errors [Refer to W376].</p> <p>The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.</p>	W 318	<p>W318 This Condition will be met as evidenced by:</p> <p>Cross reference W331 Cross reference W340 Cross reference W362 Cross reference W369 Cross reference W375 Cross reference W376</p>	11/6/09 On-going
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure preventive health services were coordinated for the completion of a recommended diagnostic procedures for one of the four clients in the sample. (Client #2)</p> <p>The finding includes: The facility's nursing staff failed to ensure follow-up on the orthopedic's recommendation as evidenced below:</p>	W 322		

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4913 EDSON PLACE, NE WASHINGTON, DC 20019		
(C4) 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)	C5 COMPLETION DATE	
W 322	<p>Continued From page 21</p> <p>Therapeutic procedures recommended in Client #2's individual support plan (ISP) dated January 23, 2009 were reviewed on October 2, 2009. The following recommendations were pending the review and approval of the orthopedic/physician.</p> <p>a. Continue right elbow brace to increase elbow extension.</p> <p>b. Continue left knee brace to increase knee extension.</p> <p>Review of Client #2's medical record on October 2, 2009, at approximately 2:11 p.m., revealed an orthopedic consult dated January 30, 2009. The orthopedist recommended that Client #2 began the initial wear of an elbow brace and a knee brace. Another recommendation was for the physical therapist to follow-up with the client's primary care physician (PCP) "to determine the next course of treatment for contractures since the braces had not affected her contractures." Continued review of the consult revealed that the client should follow-up after an appointment with her PCP. On March 21, 2009 the client was seen by her PCP, however the PCP's progress note dated March 21, 2009, failed to address the orthopedist's recommendation.</p> <p>Interview with the facility's LPN on October 2, 2009 did not provide any evidence the PCP or the PT had addressed the client's contractures.</p>	W 322	<p>W322</p> <p>This Standard will be met as evidenced by:</p> <p>Client #2's currently has an elbow brace and a knee brace that she wears daily as recommended by the Orthopedist and confirmed by the Physical Therapist. The order was signed by the primary care physician prior to implementation. All LPN's received in-service training on documentation expectations. The RN and QMRP continue to coordinate and ensure collaboration of all interventions.</p> <p>The RN will conduct regular record reviews and follow-up with the LPN and other team members. All physician orders will be signed in accordance to policy.</p>	10/30/09 On-going	
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p>	W 331			

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W 331

Continued From page 22

This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing services failed to ensure services were provided in accordance with the needs of three of the four clients in the sample. (Client's #1, #2, #3, #4, #5 and #7)

The findings include:

- The facility's nursing services failed to ensure staff implemented Client #2's discharge order.
 - Observations on September 30, 2009 at 2:02 p.m., revealed Client #2 in her wheelchair seated at the dining room table eating her lunch. Interview with the Assistant Director/Acting Qualified Mental Retardation Professional, (AQMRP) on the aforementioned date at 2:07 p.m. revealed that the client had just been discharged that morning from the hospital. Interview with the direct care staff and continued observation revealed the client was eating baked chicken, potato salad and string beans. Additionally, she was given a cup of light cranberry juice. Client #2's food was observed to be served bite sized. At approximately 2:16 p.m., the client was finished eating her lunch. The direct care staff was observed to seat the client in the facility's living room. Observation at 3:01 p.m. revealed the client appeared to be weak. At 3:07 p.m., AQMRP was observed to offer the client some flavored water.
 - Interview with the direct care staff on September 30, 2009, at 5:14 p.m. revealed that Client #2 had experience emesis, due to the inability to keep her food down from lunch. At 5:16 p.m., Client #2 was observed in her bed shaking her head from side to side. According to

W 331

W331
This Standard will be met as evidenced by:

Cross reference W192, W375, W455 and W120

- a, b, and c. Additional training was provided to all nurses to address the following: hospital discharge policy, adherence to hospital recommendations, documentation, communication between primary care physician, nurses and staff post hospitalization/emergency room visit. The RN assigned to the home conducts and completes discharge assessments and provides direction to the LPN staff to ensure all recommended procedures are followed as set forth. The Director of Nursing will monitor activities and documentation of post hospital discharges and coordination of care and take necessary actions as needed to include but not limited to; policy changes, staff deployment, disciplinary actions, and training.

10/30/09
On-going

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W 331	<p>Continued From page 23</p> <p>the direct care staff, the client had been continuously rubbing her stomach. At 5:45 p.m., an interview with the facility's Licensed Practical Nurse (LPN) revealed that she had examined Client #2 and that all her vitals were in normal range. Further interview with the LPN revealed she was not able to check the client's lungs, because she refused to turn over. According to the LPN, she had plans to notify the Primary Care Physician (PCP), but needed to be able to inform the PCP that she had checked her lungs.</p> <p>On September 30, 2009, at approximately 6:09 p.m., interview with the LPN revealed that she had contacted Client #2's PCP and was instructed to transport the client to a local emergency room.</p> <p>c. Review of the client's discharge summary from the emergency room on September 30, 2009, at approximately 10:15 p.m., revealed that the client was diagnosed with dehydration, fecal impaction, and nausea and vomiting. The aftercare instructions for nausea, vomiting, and diarrhea revealed that "it is important to rest the stomach and intestines and replace lost fluid." Continued review of the document revealed the following instruction: "Do not eat solid foods for at least 24 hours."</p> <p>At the time of the survey, there was no evidence the facility's nursing services had reviewed Client #2's emergency room discharge orders to ensure the client's health and safety.</p> <p>2. The facility's nursing staff failed to provide routine laboratory testing for Client #2 as recommended by the primary care physician (PCP) as identified below:</p>	W 331	<p>2. Interview with facility nurse and review of client record shows that attempts were made to obtain catheterization for client #2's urinalysis and culture. However, she was experiencing spotting which made it difficult to get a "clean catch". Client #2's urinalysis/culture has been completed. The RN will continue to follow-up and assist as needed to ensure timely follow-up of recommended laboratory studies.</p> <p>3. The facility nursing staff has received additional in-service training on fluid intake documentation. RN will monitor fluid records and intake weekly to ensure adherence to policy and physician orders.</p> <p>4. The Director of Nursing conducted training for all facility nursing staff on elevation of client #3's feet as ordered by physician. In addition, QMRP/RN conducted in-service staff on following PT recommendations as outlined.</p>	11/9/09 On-Going
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W331	<p>Continued From page 24</p> <p>Review of Client #2's medical record on October 1, 2009 at approximately 12:44 p.m., revealed a Medical Evaluation dated January 22, 2009. Further review of the evaluation revealed that the primary care physician (PCP) ordered a urinalysis and urine culture with sensitivity every six months. According to the review of Client #2's medical records on October 1, 2009 at approximately 10:05 a.m., revealed the last documented laboratory studies for the aforementioned tests were dated January 8, 2009.</p> <p>In an interview with the facility's licensed practical nurse (LPN) on October 5, 2009, at 3:19 p.m., it was acknowledged that the urinalysis and the urine culture had not been performed every six months as recommended by the PCP. Although further review of the record and interview with the LPN revealed Client #2 had lab work conducted in June 2009, there was no documented evidence that the urinalysis and urine culture had been done as ordered at that time.</p> <p>3. The facility's nursing services failed to accurately document Client #5's tube feeding on the Fluid Intake Monitoring Sheet.</p> <p>Interview with the nurse on October 1, 2009 at 7:39 a.m., revealed that the volume of Client #5's G-tube feeding had been decreased from 4 cans to 3 cans of Resource daily due to his weight gain.</p> <p>Record review on October 2, 2009 at 9:40 a.m., revealed on September 28, 2009, the primary care physician (PCP) prescribed the diet change to Resource 2.0, 237 cc, to three times daily (7:00 a.m., 12:00 noon, 5:00 p.m., as recommended by the nutritionist. The review of the medication</p>	W331	<p>5. The facility nurse was immediately removed from the home and is no longer employed with the company, effective 10.10.09. The RN will continue to conduct medication pass observations and address concerns as they arise as evidenced by training and/or corrective actions.</p> <p>6. Cross reference W375</p> <p>7. Cross reference W455</p> <p>8. Cross reference W120</p>	
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W331	<p>Continued From page 25</p> <p>administration record (MAR) revealed the new physician's order dated October 28, 2009 for Resource 2.0, 297 cc at 7:00 a.m., 12:00 noon and 5:00 p.m. The review of the Fluid Intake Monitoring Sheet for the G-tube, however, documented that 474 cc of tube feeding was administered to the client during the 4:00 p.m. to 12:00 a.m. (evening shift). There was no evidence that the facility nursing services ensured that the documentation on the Fluid Intake Monitoring Sheet accurately reflected the amount of tube feeding administered to the client during the evening shift on September 28, 29, and 30, 2009.</p> <p>4. The facility's nursing services failed to implement a system to keep Client #3's feet elevated as prescribed by the primary care physician (PCP) as evidenced below:</p> <p>On October 1, 2009 at 7:08 p.m., Client #3 was observed seated in her wheelchair with her feet resting on a pillow on her vinyl covered foot box. On October 2, 2009, after dinner, two staff was observed transferring the client from her wheelchair to a recliner.</p> <p>On October 5, 2009 at 2:39 p.m., record review revealed a telephone physician's order (PO) dated August 29, 2009 which read, "keep feet elevated. Monitor every shift for edema, plus (+) if any edema, minus (-) if no edema."</p> <p>The facility's nurses failed to ensure Client #3's feet were kept elevated as prescribed in the August 29, 2009 order.</p> <p>5. The medication nurse failed to verify physician's orders prior to administering</p>	W331			

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W331	<p>Continued From page 26</p> <p>medications as identified below:</p> <p>During the evening medication administration on September 30, 2009, at approximately 7:26 p.m., the Licensed Practical Nurse (LPN) was observed to pour 30 cc of Lactulose for Client #1. The nurse attempted to administer the medication, but was informed by the surveyor that the label on the bottle indicated that the medication was to be administered in the morning.</p> <p>The LPN reviewed the client's physician's order and verified that the medication was ordered for the morning. The LPN proceeded to pour the Lactulose back into the medication bottle.</p> <p>6. [Cross Refer to W375]. The facility's nursing staff failed to ensure that drug administration errors were recorded for (Client's #2 and #4).</p> <p>7. [Cross Refer to W455]. The facility's nursing staff failed to provide a treatment program for the prevention and control of infection for (Clients #1, #4, #7).</p> <p>8. [Cross Refer to W120] The facility failed to enact an effective system of oversight to ensure Client #4's day program provided his servings of Boost as prescribed on his Physician's Orders.</p>	W331		
W340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p>	W340		

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WV 340	<p>Continued From page 27</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing staff failed to provide recommended training to day program staff, for two of the seven clients in the sample. (Clients #3 and #6)</p> <p>The findings include:</p> <p>1. On Friday, October 9, 2009 at 12:39 p.m., interview with a direct support staff person at Client #6's day program revealed that he had begun working with the client on Tuesday, October 5, 2009. At that moment, Client #6 was seated in her wheelchair, wearing her prescribed trunk brace. The brace, however, was fitted loosely and extended up, over her breasts. The staff said the brace was positioned too high on her trunk. He then pointed to her lower back, saying that the brace should be down at her waistline. When positioned properly, at the waist, the top edge of the brace is below the breasts. Further interview revealed that Client #6 had arrived from home wearing the trunk brace in that position, at approximately 12:00 p.m. The client had been given lunch upon her arrival and she was to remain seated upright for approximately 1 hour after the meal. [Note: When interviewed at approximately 1:05 p.m., the physical therapist stated that while there was no immediate danger presented by the current brace position (too high), he thought it could present discomfort, given how it pushed against the client's breasts.]</p> <p>a. According to the staff, he did not receive training for Client #6's trunk brace when he first began working with her. Instead, the physical therapist provided training three days later, on Thursday, October 8, 2009. Subsequent review</p>	WV 340	<p>W340</p> <p>This Standard will be met as evidenced by:</p> <p>1a,b,c. Review of day program progress notes did not indicate that a new staff is currently working with client #6. Day program has a number of LPN's and a Director of Nursing who is very familiar with client #6 HMCP and wearing of back braces due to her scoliosis. The facility RN and QMRP conducted follow up with day program Director to ensure all employee receive training on client #6 adaptive support equipment and health management care plan. In addition, discussions also included outline of training to all new employee prior to working with client #6 and all other client that attend the day program.</p>	11/6/09 On-going

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W 340	<p>Continued From page 28</p> <p>of staff training documents at the day program confirmed that the PT, who also worked in the home, had conducted the training, as reported.</p> <p>b. The staff further indicated that he was unaware of Client #6's diagnoses, and had not yet received training on her Health Management Care Plan (HMCP). Review of day program staff training documents confirmed his account.</p> <p>c. The staff person who had provided direct support for Client #6 up until Friday, October 2, 2009 reportedly had transferred to a different day program facility operated by the same agency. The complaint had included an allegation that the (former) staff had been unfamiliar with the client's diagnostic profile, health risks and HMCP. At 3:30 p.m., interview with the day program case manager indicated that their staff had first received training on HMCPs on October 1, 2009. Moments later review of signature sheets failed to show evidence that the (former) staff person in question had been in attendance. There was no evidence presented to verify that the staff had received training on Client #6's HMCP.</p> <p>2. On October 9, 2009, Client #3's day program records showed that on September 3, 2009, the group home had faxed to them physician's orders that reduced the client's daily fluid intake. She was to be restricted to no more than 1000cc's per day. Later the same day, the group home faxed an amended mealtime protocol (dated September 3, 2009) to the day program, instructing them to offer her 1/2 cup fluids at morning break and 1/2 cup at lunch. The group home provided no further instructions.</p> <p>a. On October 9, 2009 at 1:18 p.m., review of</p>	W 340	<p>2. a.& b. Review of record indicated that client #1's fluid recommendation has been implemented as ordered by physician. The Director of Nursing and RN's have conducted several trainings on adherence to adequate fluid intake and adherence to physician orders. RN will monitor implementation and performance of LPN staff to ensure competency. In-service training has been completed at the day program. In addition, fluid intake sheets and a measuring cup have been provided to the day program to ensure continuity of care. RN/QMRP/LPN/Home Manager will continue to visit the day program at least twice monthly to monitor client #1's lunch intake and to ensure compliance with the fluid intake as ordered by the physician. Reference response to W120.</p>	
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W 340	<p>Continued From page 29</p> <p>Client #3's day program habilitation records revealed three communications that were sent home after the day program received the new fluid restriction order. On September 3, 2009, the day program asked the home to provide a sample fluid chart (for charting intake). They also requested training on how the group home wanted them to document her fluid intake. The next request was sent home on September 8, 2009, indicating the need for a fluid intake chart and training for day program staff. A third communication was sent home on September 16, 2009, again requesting a fluid chart with appropriate training. The group home, however, failed to respond timely to the requests.</p> <p>Further review of Client #3's record revealed that a government case worker had visited the day program on September 23, 2009 at which time she contacted the group home and requested that they address the day program's requests. According to the record, a nurse brought a sample fluid intake chart to the day program on September 24, 2009 and provided training for their staff. This was verified through interview with the day program case manager shortly after 3:00 p.m.</p> <p>It should be noted, however, that from September 24, 2009 - October 1, 2009, day program staff had estimated the amount of fluids being offered to Client #3 at morning break and at lunch.</p> <p>b. [Cross Refer to W120.1]. On October 1, 2009 at 10:46 a.m., staff at the day program did not use a graduated measuring device to pour Client #3's juice at morning break. Instead, the staff visually poured fluid into a spout cup, stopping when it looked to be half full.</p>
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W 340

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4915 EDSON PLACE, NE WASHINGTON, DC 20019	
(04) 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)	(05) COMPLETION DATE
W 362	<p>483.460(J)(1) DRUG REGIMEN REVIEW</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly for one of four sampled clients. (Client #5)</p> <p>The finding includes:</p> <p>Interview with the primary LPN on October 5, 2009 at 2:57 p.m. revealed the policy was that the pharmacist review each client's medication regimens every three months.</p> <p>Record review on October 5, 2009 at 3:30 p.m. revealed Client #5's medication regimen was last reviewed on April 15, 2009. A note on the medication review form dated July 7, 2009 stated "Client in hospital." The client was readmitted to the hospital on July 13, 2009. At the time of the survey, there was no evidence that Client #5's medication regimen was reviewed at the required frequency to obtain relevant input from the pharmacist.</p>	W 362	<p>W362 This Standard will be met as evidenced by:</p> <p>The RN will monitor and review all pharmacy reviews for compliance. The RN in coordination with the IDT will provide the pharmacist information related to any changes in behavior, new medications, etc.. Client #6's was hospitalized during the last pharmacist visit. The RN will follow-up and direct LPN staff as needed to ensure that all regular scheduled pharmacy reviews are completed. The RN will further evaluate if additional policies and/or guidelines are needed to further support this process. The Director of Nursing will monitor pharmacy reviews and documentation to further ensure compliance and follow-up as needed on all concerns as they arise.</p>	11/9/09 On-going
W 369	<p>483.460(K)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure all drugs</p>	W 369		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 090119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
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NAME OF PROVIDER OR SUPPLIER

INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

4516 EDSON PLACE, NE
WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 369

Continued From page 31
ere administered without error for two of the four clients (Clients #2 and #4) included in the sample.

The findings include:

1. Observation of the medication administration on September 30, 2009, at approximately 7:59 p.m., revealed Client #2 was to receive three drops of baby oil in each ear. The LPN was observed to administer the entire amount of baby oil suctioned into the tube dropper without distinguishing the number of drops ordered (amount of oil administered was far greater than three drops) in Client #2's left ear. Interview with the LPN on September 30, 2009, at approximately 10:00 p.m. revealed that she had difficulty administering the drops, because something was wrong with Client #2's ear lobe. In addition to the baby oil that was administered in the client's left ear, the LPN confessed that she only administered one drop of the baby oil in the client's right ear.

Review of Client #2's medical record on October 1, 2009, beginning at approximately 10:15 a.m., revealed a Physician's Order (PO) dated September 2009. Review of the PO revealed the client was prescribed Baby Oil; instill three drops to both ears twice daily three times a week on Monday, Wednesday, and Friday. At the time of the medication administration, however, Client #2 was not observed to receive the prescribed three drops of baby oil to both ears. The facility failed to ensure Client #2's baby oil was administered without error.

2. During the evening medication administration on September 30, 2009, at approximately 7:16

W 369

W369
This Standard will be met as evidenced by:

Reference responses to W331, #5.
In addition, all physician order has been reviewed by RN and method of medication administration has been clearly outlined on each order. RN has provided additional training to all nursing staff on medication administration and following physician order as prescribed.

10/30/09
On-going

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 EDSON PLACE, ME WASHINGTON, DC 20019
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(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 369	<p>Continued From page 32</p> <p>p.m., revealed Client #4 received Haldol 2 mg, Dilantin 50 mg, Antacid 500 mg, and Amoxicillin 125 mg. Continued observation of the medication administration revealed the LPN crushed Client #4's medications, mixed them with fruit butter and water, before administering.</p> <p>Review of Client #4's medical record on October 1, 2009, beginning at approximately 10:15 a.m. revealed a Physician's Order (PO) dated September 2009. Review of the PO did not evidence that Client #4's medication should be crushed. At the time of the survey, the facility failed to ensure Client #4's medications were administered without error.</p> <p>3. During the evening medication administration on September 30, 2009, at approximately 7:16 p.m., Client #4 received Haldol 2 mg, Dilantin 50 mg, Antacid 500 mg, and Amoxicillin 125 mg. The facility's LPN was observed to drop the Amoxicillin on the medication tray, proceeded to pick up the pill with her hand, and then placed it in a medication cup. Continued observation of the medication administration revealed the LPN crushed Client #4's medications and at approximately 7:29 p.m., was observed to knock the cup of crushed medications over on the medication tray. She was observed to use a spoon to scoop the crushed medications back into a medication cup. Continuing to prepare the client's medications, the LPN was observed to mix the crushed medications with fruit butter and water, after which she administered them to Client #4. At the time of the medication administration, the facility failed to ensure Client #4's medications were administered without error.</p>	W 369		
W 375	483.480(k)(8) DRUG ADMINISTRATION	W 375		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 10/09/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4845 EDSON PLACE, NE WASHINGTON, DC 20019
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(04) 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)	(05) COMPLETION DATE
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W 375	<p>Continued From page 33</p> <p>The system for drug administration must assure that drug administration errors and adverse drug reactions are recorded.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that drug administration errors were recorded for two of the four clients residing in the facility. (Clients #2 and #4)</p> <p>The findings included:</p> <p>[Cross Refer W369] During the evening medication administration on September 30, 2009, beginning at approximately 7:16 p.m., the Licensed Practical Nurse (LPN) was observed to not administer Clients #2 and #4 without errors.</p> <p>At the time of the medication administration, however, there was no documented evidence that the LPN recorded the aforementioned errors in Clients #2 and #4's Medication Administration Record (MAR) or medical record.</p>	W 375	<p>W375 This Standard will be met as evidenced by:</p> <p>Reference response to W369.</p>	10/30/09 On-going
W 436	<p>482.470(g)(2) SPACE AND EQUIPMENT</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 the record review, the facility failed to ensure that</p>	W 436		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G119	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(C3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4816 EDSON PLACE, NE WASHINGTON, DC 20019		
(K4) 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)	(K5) COMPLETION DATE	
W 436	Continued From page 34 wheelchairs were maintained in good repair for two of the four clients in the sample (Clients #5). The findings include: On October 5, 2009 at 5:20 p.m., Client #5's wheelchair was observed in his bedroom. The left heel strap at the back of the footrest was detached. There was no support to prevent the left heel from sliding off the footrest/plate. The footrests and foot plates were also noted to be misaligned. Interview with the residential director (RD) and the AQMRP indicated that repairs had been made to the client's footrest, however, the screw necessary to secure the heel strap was missing. Interview with the AQMRP on October 5, 2009 at 5:25 p.m. revealed that recent repairs had been made to the client's wheelchair. The wheelchair repair documentation was requested. On October 5, 2009 at 5:40 p.m., the review of a wheelchair evaluation dated July 17, 2009 revealed the recommendations included: (a) Align footrests and foot plates; (b) Secure left heel strap. Documentation to determine when the wheelchair repairs were made was not available. At the time of the survey, there was no evidence the wheelchair had been maintained as recommended by the IDT.	W 436	W436 This Standard will be met as evidenced by: The policies and procedures related to timely procurement of necessary adaptive equipment is being revised and updated to include recent changes in DDS policy and procedures as well as internal changes which will require procurement of adaptive equipment within 72 hours of evaluation or provision, within 72 hours of evaluation, documentary evidence detailing the status of efforts to secure the adaptive equipment pending receipt will be documented and maintained in the Adaptive equipment book. The QMRP is responsible for oversight and management of the adaptive equipment process. Training by the designated therapists on use will occur within 5 days of the delivery and monitoring of the same by the therapist on the use and condition of the adaptive equipment will occur as determined by the IDT.	11/6/09 On-going	
W 455	483.470(f)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4816 EDSON PLACE, NE WASHINGTON, DC 20019
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W 455	<p>Continued From page 35</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmissions of infection for three of the four clients (Clients #1, #4, and #7) residing in the facility.</p> <p>The findings include:</p> <p>The facility's nursing staff failed to ensure infection control standards were used during the medication administration as evidenced below:</p> <p>1. During the evening medication administration on September 30, 2009, beginning at approximately 7:16 p.m., Client #4 received Haldol 2 mg, Dilantin 60 mg, Antacid 500 mg, and Amoxicillin 125 mg. The facility's LPN was observed to drop the Amoxicillin on the medication tray, proceeded to pick up the pill with her hand, and then placed it in a medication cup. Further observation revealed the LPN punched another medication (Dilantin) from the bubble pack into her hand (without gloves) and then into the medication cup. Continued observation of the medication administration revealed the LPN crushed Client #4's medications and at approximately 7:29 p.m., was observed to knock the cup of crushed medications over on the medication tray. She was observed to use a spoon to scoop the crushed medications back into the medication cup. Continuing to prepare the client's medications, the LPN was observed to mix the crushed medications with fruit butter and water, after which she administered them to Client #4.</p> <p>At the time of the survey, the facility's nursing staff failed to ensure a sanitary environment was</p>	W 455	<p>W455 This Standard will be met as evidenced by: 1. Reference W369</p>	10/30/09 On-going
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G118	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 10/09/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, NE WASHINGTON, DC 20018
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(K4) 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 (SUCH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(K5) COMPLETION DATE
W 455	<p>Continued From page 36 provided during the administration of medication for Client #4.</p> <p>2. Observation of the evening medication administration on September 30, 2009 at 7:26 p.m. revealed Client #1 received Levetiracetam 750 mg. The LPN was observed to drop the client's pill on the medication tray, and then picked the pill up with her bare hand and placed it in a medication cup. After the LPN placed the pill in the cup, she was observed to administer it to Client #1.</p> <p>At the time of the survey, the facility's nursing staff failed to ensure a sanitary practices were being implemented during the administration of medication for Client #1.</p> <p>3. During the observation of the evening medication administration on September 30, 2009 beginning at 7:17 p.m. revealed Client #7 received Lactulose. Continued observation revealed the LPN wipe the client's mouth, and placed the spoon on the medication tray. The LPN was observed to use the spoon to continue the administration of Client #7's medications. At the time of the survey, the facility's nursing staff failed to ensure a sanitary environment was provided during the administration of medication for Client #7.</p>	W 455		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HF003-0000	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4915 EDSON PLACE, NE WASHINGTON, DC 20019	

(C4) 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)	(C5) COMPLETE DATE
1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted on September 30, 2009 through October 5, 2009. A random sampling of four residents from the residential population of five females and two males was selected for the survey. The results of the survey was based on observations in the home and at three day programs. Administrative, nursing and direct care staff interviews was conducted, as well as a review of the resident and administrative records, including a review of the unusual incident reports.</p> <p>Based on the initial findings of the survey, on September 30, 2009 at 9:45 p.m., it was determined that nursing practice posed an immediate and serious threat to residents residing in the Group Home for the Mentally Retarded Person (GHMRP). The agency's Administrator and the facility's Assistant Director/Acting Qualified Mental Retardation Professional (QMRP) were informed of the emergent findings at 11:33 p.m.</p>	1 000	<p>3502.2(c)</p> <p>This Statute will be met as evidenced by:</p> <p>QMRP will ensure that Nutritional assessments are completed monthly unless otherwise indicated by the IDT. In such cases the Nutritionist will complete quarterly reviews as outlined in (GHMRP). The quarterly assessment has been filed and is available for review.</p> <p>QMRP and RN will monitor on an ongoing basis to ensure that the monthly and quarterly reviews are completed as outlined.</p>	11/6/09 On-going
1 043	<p>3502.2(c) MEAL SERVICE / DINING AREAS</p> <p>Modified diets shall be as follows:</p> <p>(c) Reviewed at least quarterly by a dietician.</p> <p>This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure that the resident with a modified diet had been reviewed at least quarterly by the consulting dietician for one of the four residents (Resident #2) included in the sample.</p> <p>The finding includes:</p>	1 043		

Health Regulation Administration

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(C6) DATE

STATE FORM

585511

If continuation sheet 1 of 22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-6036	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4915 EDSON PLACE, NE WASHINGTON, DC 20019		
(K4) 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)	(C5) COMPLETE DATE
1043	Continued From page 1 Observations on September 30, 2009 at 2:02 p.m., revealed Resident #2 in her wheelchair seated at the dining room table eating her lunch which consisted of bite-sized pieces of baked chicken, potato salad and string beans. Interview with the Assistant Director/Acting Qualified Mental Retardation Professional, (AQMRP) on the aforementioned date at 2:07 p.m. verified Resident #2 was prescribed her meals to be served in a "bite-sized" consistency. Review of Resident #2's record on October 2, 2009 at 3:43 PM revealed a Nutritional Assessment was conducted on January 11, 2009. According to the assessment, Resident #1 had a recommendation for a 1500 calorie, bite size diet. At the time of the survey, the GHMRP failed to show evidence that a dietitian or nutritionist had reviewed Resident #2's modified diet plan since the last quarterly assessment conducted in April 2009.	1043		
1139	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure a complete and accurate accounting of resident's funds for three of the four sampled residents. (Resident's #2, #3 and #4) The findings include: Record review and interview with the GHMRP Acting Qualified Mental Retardation Professional	1139	3508.7 This Statute will be met as evidenced by: Reference responses to W139 and W140.	10/30/09 On-going

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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 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, NE WASHINGTON, DC 20019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
1189	<p>Continued From page 2</p> <p>(ADM) and House Manager (HM) revealed the facility failed to ensure an effective system of monitoring and managing resident's funds.</p> <p>1. Staff interview and record review on October 1, 2009 at approximately 4:44 p.m., revealed Resident #2's bank statements reflected withdrawals totaling \$950.09. The following withdrawals were documented between the dates of January 1, 2009 and June 30, 2009 as identified below:</p> <ul style="list-style-type: none"> a. \$150.00 withdrawn on 01/28/2009 b. \$200.00 withdrawn on 03/12/2009 c. \$100.00 withdrawn on 03/24/2009 d. \$500.00 withdrawn on 06/15/2009 <p>Although \$950.09 was withdrawn, only \$192.57 in receipts were available for review. The expenditures are listed below:</p> <ul style="list-style-type: none"> a. 04/06/09 "Clothing" = \$21.29 b. 03/31/09 "Beauty Supply" = \$21.28 c. 03/28/09 "Hair Braiding" = \$150.00 <p>The difference of \$757.52 was unaccounted for at the time of survey. There was no documented evidence or receipts on file to substantiate what happened to the remaining funds.</p> <p>2. Staff interview and record review on October 1, 2009 at approximately 4:15 p.m., revealed Resident #3's bank statements reflected withdrawals totaling \$4,153.78. The following withdrawals were documented between the dates of March 1, 2009 and July 31, 2009 as identified below:</p> <ul style="list-style-type: none"> a. \$1,127.00 withdrawn on 03/12/09 b. \$90.00 withdrawn on 3/24/09 	1189			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD83-0036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 EDSON PLACE, NE WASHINGTON, DC 20018
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(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
1189	<p>Continued From page 3</p> <p>c. \$2,000.00 withdrawn on 05/08/09 d. \$448.78 withdrawn on 06/05/2009 e. \$500.00 withdrawn on 08/15/2009</p> <p>Although \$4,163.78 was withdrawn, only \$2,983.71 in receipts were available for review. The expenditures are listed below:</p> <p>a. No Date: "Department Store" = \$747.30 b. 03/28/2009 "Wholesale Club" = \$242.00 c. 05/13/2009 "Massage Parlor" = \$1,630.00 d. 04/01/2009 "Department Store" = \$85.92 e. 05/06/2009 "Discount Store" = \$26.50 f. 06/17/2009 "Clothing" = \$49.98 g. 07/01/2009 "Department Store" = \$87.84 h. 07/01/2009 "Department Store" = \$41.34 i. 07/28/2009 "Hair Braiding" = \$50.00 j. No Date: "Department Store" = \$162.83</p> <p>The difference of \$1,180.07 was unaccounted for at the time of survey. There was no documented evidence or receipts on file to substantiate what happened to the remaining funds.</p> <p>3. Staff interview and record review on October 1, 2009 at approximately 4:55 p.m. revealed Resident #4's bank statements reflect \$200 was withdrawn on June 16, 2009. Further record review revealed there were no receipts on record at the facility during the time of survey to validate the withdrawal.</p> <p>Interview with the Acting QMRP and HM on October 2, 2009 at 10:21 a.m. revealed they were also having difficulty following the record keeping for the finances.</p>	1189	<p>1222</p> <p>3510.3</p> <p>This Statute will be met as evidenced by:</p> <p>Cross Reference responses to</p> <p>W192, W331, W130, W369, W375, and W340 for #1,2,3,4, and 5.</p>	11/9/09 On-going
1222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service</p>	1222		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14FD03-0036	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG 1722	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 1722	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Continued From page 4</p> <p>training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for four of seven residents (Residents #2 #3, #4 and #6) residing in the facility.</p> <p>The findings include:</p> <p>The GHMRP's nursing services failed to ensure staff were adequately trained to implement Resident #2's discharge orders as evidenced below:</p> <p>1. Observations on September 30, 2009 at 2:02 p.m. revealed Resident #2 in her wheelchair seated at the dining room table eating her lunch. Interview with the Assistant Director/Acting Qualified Mental Retardation Professional, (QMRP) on the aforementioned date at 2:07 p.m. revealed that the resident had just been discharged that morning from the hospital. Interview with the direct care staff and continued observation revealed the resident was eating baked chicken, potato salad and string beans. Additionally, she was given a cup of light cranberry juice. Resident #2's food was observed to be served bite sized.</p> <p>Review of the resident's discharge summary from the emergency room revealed that the resident was diagnosed with dehydration, fecal impaction, and nausea and vomiting. The aftercare instructions for nausea, vomiting, and diarrhea</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(04) 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)	(05) COMPLETE DATE	
1222	<p>Continued From page 5</p> <p>revealed that "It is important to rest the stomach and intestines and replace lost fluid." Continued review of the document revealed the following instruction: "Do not eat solid foods for at least 24 hours." The LPN on duty failed to provide the direct care staff with instructions to address the ER recommendation.</p> <p>Review of the on duty Licensed Practical Nurse's (LPN) orientation training record on October 5, 2009, revealed that the LPN had been trained on "Hospitalization Discharge Orders" on July 23, 2009.</p> <p>At the time of the survey, the GHMRP failed to ensure the nursing staff had been effectively trained to review and implement "hospitalization discharge orders." [See Federal Deficiency Report Citation W331]</p> <p>2. [Cross Refer to Federal Deficiency Report Citation W130]. The GHMRP failed to ensure nursing staff had been trained in providing privacy during the administration of medications for Residents #3 and #6.</p> <p>3. [Cross Refer to Federal Deficiency Report Citation W369]. Review of the GHMRP's nursing training on October 5, 2009 revealed the LPN was trained on the GHMRP's Medication Administration Protocol on July 23, 2009. At the time of the survey, the GHMRP failed to ensure nursing staff had been effectively trained to review the resident's physician's orders before administering their medications.</p> <p>4. [Cross Refer to Federal Deficiency Report Citation W375]. The GHMRP failed to ensure nursing staff had been trained to ensure that drug administration errors were recorded for</p>	1222			

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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 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4616 EDSON PLACE, NE WASHINGTON, DC 20019		
DCG 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)	(X4) COMPLETE DATE
1222	Continued From page 6 (Residents #2 and #4). 5. [Cross refer to Federal Deficiency Report Citation W340]. Resident #6's day program staff had not received training on the resident's diagnostic profile, health risks and Health Management Care Plan. Resident #3's day program staff had not received training on implementation of the resident's fluid restriction.	1222		
1224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure training was provided to each staff in the area of Mental Retardation for thirteen out of thirteen staff. (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the training records on October 5, 2009 at approximately 3:14 p.m. revealed, none of the thirteen (13) staff received training in mental retardation. Additional interview with the Acting QMRP on the same date and time revealed, there was additional signature sheets for trainings being kept at the main office.	1224	1224 3510.5 (a) This Statute will be met as evidenced by: All staff receive training on mental retardation, Human Development through the life cycle and infection control at the time of hire. Copies of the documents are forwarded to the Home Manager for filing into the training book located in the GHMRP. QMRP/Home Manager/Training Director will conduct ongoing audits of the training records to ensure compliance with this standard. All employees have been trained and the information is on file for review.	11/6/09 On-going

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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 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 224	Continued From page 7 and not on file in the home. The GHMRP failed to ensure all staff received training in the area of mental retardation as required by this section.	I 224		
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death): This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) only ensured three out of thirteen staff received training in the area of Human Development. (Staff #4, #11, and #12) The finding includes: Interview with the GMRP and review of the training records on October 5, 2009 at approximately 2:30 p.m. revealed, out of the thirteen (13) staff records reviewed, the GHMRP provided documentation which reflected that only three staff had received training in Human Development. The GHMRP failed to ensure all staff received training in the area of Human Development as required by this section.	I 225	3510.5 (b) This Statute will be met as evidenced by: Reference responses to W192. Also, reference response to 3510.5(a)	10/30/09 On-going
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 226		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 10/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(24) 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)	(25) COMPLETE DATE
1227	Continued From page 10 The GHMRP failed to ensure all staff received training as required by this section.	1227		
1228	3510.6(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident's rights; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) only ensured four out of thirteen staff received training in the area of Resident's Rights. (Staff #2, #3, #5, and #11) The finding includes: Interview with the Acting Qualified Mental Retardation Professional (AQMRP) and review of the training records on October 5, 2009 at approximately 3:09 p.m. revealed, out of the thirteen (13) staff records reviewed, the GHMRP provided documentation which reflected that only four staff had received training in Resident's Rights.	1228		
1401	3520.3 PROFESSIONAL SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment	1401	1401 3520.3 This Statute will be met as evidenced by: Cross reference responses to; W104, W120, W192, W331, W375, and W455 for a., b., c., 1,2,3,4.	10/30/09 On-going

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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 10/09/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019
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(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)	DOE COMPLETE DATE
1401	<p>Continued From page 11</p> <p>services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) nursing services failed to ensure services were provided in accordance with the needs of three of the four residents in the sample. (Resident's #1, #2, #3, #4, #5 and #7)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's nursing services failed to ensure staff implemented Resident #2's discharge order. <ol style="list-style-type: none"> Observations on September 30, 2009 at 2:02 p.m., revealed Resident #2 in her wheelchair seated at the dining room table eating her lunch. Interview with the Assistant Director/Acting Qualified Mental Retardation Professional (AQMRP) on the aforementioned date at 2:07 p.m. revealed that the resident had just been discharged that morning from the hospital. Interview with the direct care staff and continued observation revealed the resident was eating baked chicken, potato salad and string beans. Additionally, she was given a cup of light cranberry juice. Resident #2's food was observed to be served bite sized. At approximately 2:18 p.m., the resident was finished eating her lunch. The direct care staff was observed to seat the resident in the facility's living room. Observation at 3:01 p.m. revealed the resident appeared to be weak. At 3:07 p.m., AQMRP was observed to offer the resident some flavored water. Interview with the direct care staff on 	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019	

(C4) 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)	(C5) COMPLETE DATE
1401	<p>Continued From page 12</p> <p>September 30, 2009, at 5:14 p.m. revealed that Resident #2 had experience emesis, due to the inability to keep her food down from lunch. At 5:16 p.m., Resident #2 was observed in her bed shaking her head from side to side. According to the direct care staff, the resident had been continuously rubbing her stomach. At 5:46 p.m., an interview with the GIMRP's Licensed Practical Nurse (LPN) revealed that she had examined Resident #2 and that all her vitals were in normal range. Further interview with the LPN revealed she was not able to check the resident's lungs, because she refused to turn over. According to the LPN, she had plans to notify the Primary Care Physician (PCP), but needed to be able to inform the PCP that she had checked her lungs.</p> <p>On September 30, 2009, at approximately 8:09 p.m., interview with the LPN revealed that she had contacted Resident #2's PCP and was instructed to transport the resident to a local emergency room.</p> <p>c. Review of the resident's discharge summary from the emergency room on September 30, 2009, at approximately 10:15 p.m., revealed that the resident was diagnosed with dehydration, fecal impaction, and nausea and vomiting. The aftercare instructions for nausea, vomiting, and diarrhea revealed that "It is important to rest the stomach and intestines and replace lost fluid." Continued review of the document revealed the following instruction: "Do not eat solid foods for at least 24 hours."</p> <p>At the time of the survey, there was no evidence the facility's nursing services had reviewed Resident #2's emergency room discharge orders to ensure the resident's health and safety.</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-8038	(02) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
1401	<p>Continued From page 13</p> <p>2. The GHMRP's nursing staff failed to provide routine laboratory testing for Resident #2 as recommended by the primary care physician (PCP) as identified below.</p> <p>Review of Resident #2's medical record on October 1, 2009 at approximately 12:44 p.m., revealed a Medical Evaluation dated January 22, 2009. Further review of the evaluation revealed that the primary care physician (PCP) ordered a urinalysis and urine culture with sensitivity every six months. According to the review of Resident #2's medical records on October 1, 2009 at approximately 10:05 a.m., revealed the last documented laboratory studies for the aforementioned tests were dated January 8, 2009.</p> <p>In an interview with the GHMRP's licensed practical nurse (LPN) on October 5, 2009, at 3:19 p.m., it was acknowledged that the urinalysis and the urine culture had not been performed every six months as recommended by the PCP. Although further review of the record and interview with the LPN revealed Resident #2 had lab work conducted in June 2009, there was no documented evidence that the urinalysis and urine culture had been done as ordered at that time.</p> <p>3. The GHMRP's nursing services failed to accurately document Resident #5's tube feeding on the Fluid Intake Monitoring Sheet.</p> <p>Interview with the nurse on October 1, 2009 at 7:39 a.m., revealed that the volume of Resident #5's G-tube feeding had been decreased from 4 cans to 3 cans of Resource daily due to his weight gain.</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HPC02-9036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, 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
1401	Continued From page 14 Record review on October 2, 2009 at 9:40 a.m., revealed on September 28, 2009, the primary care physician (PCP) prescribed the diet change to Resource 2.0, 237 cc, to three times daily (7:00 a.m., 12:00 noon, 5:00 p.m., as recommended by the nutritionist. The review of the medication administration record (MAR) revealed the new physician's order dated October 28, 2009 for Resource 2.0, 237 cc at 7:00 a.m., 12:00 noon and 5:00 p.m. The review of the Fluid Intake Monitoring Sheet for the G-tube, however, documented that 474 cc of tube feeding was administered to the resident during the 4:00 p.m. to 12:00 a.m. (evening shift). There was no evidence that the facility nursing services ensured that the documentation on the Fluid Intake Monitoring Sheet accurately reflected the amount of tube feeding administered to the resident during the evening shift on September 28, 29, and 30, 2009. 4. The GHMRP's nursing services failed to implement a system to keep Resident #3's feet elevated as prescribed by the primary care physician (PCP) as evidenced below: On October 1, 2009 at 7:08 p.m., Resident #3 was observed seated in her wheelchair with her feet resting on a pillow on her vinyl covered foot box. On October 2, 2009, after dinner, two staff was observed transferring the resident from her wheelchair to a recliner. On October 6, 2009 at 2:39 p.m., record review revealed a telephone physician's order (PO) dated August 29, 2009 which read, "keep feet elevated. Monitor every shift for edema, plus (+) if any edema, minus (-) if no edema."	1401		

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If continuation sheet 15 of 22

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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 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4815 EDSON PLACE, NE WASHINGTON, DC 20019	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1401	<p>Continued From page 15</p> <p>The GHMRP's nurses failed to ensure Resident #3's feet were kept elevated as prescribed in the August 29, 2009 order.</p> <p>5. The medication nurse failed to verify physician's orders prior to administering medications as identified below:</p> <p>During the evening medication administration on September 30, 2009, at approximately 7:28 p.m., the Licensed Practical Nurse (LPN) was observed to pour 30 cc of Lactulose for Resident #1. The nurse attempted to administer the medication, but was informed by the surveyor that the label on the bottle indicated that the medication was to be administered in the morning.</p> <p>The LPN reviewed the resident's physician's order and verified that the medication was ordered for the morning. The LPN proceeded to pour the Lactulose back into the medication bottle.</p> <p>6. [Cross Refer to Federal Deficiency Report Citation W675]. The GHMRP's nursing staff failed to ensure that drug administration errors were recorded for (Resident's #2 and #4).</p> <p>7. [Cross Refer to Federal Deficiency Report Citation W655]. The GHMRP's nursing staff failed to provide a treatment program for the prevention and control of infection for (Residents #1, #4, #7).</p> <p>8. [Cross Refer to Federal Deficiency Report Citation W120] The GHMRP failed to enact an effective system of oversight to ensure Resident #4's day program provided his servings of Boost as prescribed on his Physician's Orders.</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4915 EDSON PLACE, NE WASHINGTON, DC 20019	

(4) 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)	(5) COMPLETE DATE
1-473	<p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record verification, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure all drugs are administered without error for two of the four residents (Residents #2 and #4) included in the sample.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of the medication administration on September 30, 2009, at approximately 7:50 p.m., revealed Resident #2 was to receive three drops of baby oil in each ear. The LPN was observed to administer the entire amount of baby oil suctioned into the tube dropper without distinguishing the number of drops ordered (amount of oil administered was far greater than three drops) in Resident #2's left ear. Interview with the LPN on September 30, 2009, at approximately, 10:00 p.m. revealed that she had difficulty administering the drops, because something was wrong with Resident #2's ear tabs. In addition to the baby oil that was administered in the resident's left ear, the LPN confessed that she only administered one drop of the baby oil in the resident's right ear. <p>Review of Resident #2's medical record on October 1, 2009, beginning at approximately 10:15 a.m., revealed a Physician's Order (PO) dated September 2009. Review of the PO revealed the resident was prescribed Baby Oil; instill three drops to both ears twice daily three times a week on Monday, Wednesday, and</p>	1-473	<p>3522.4</p> <p>This Statute will be met as evidenced by: Cross reference response to W130, W140</p>	10/30/09 On-going

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4511 EDSON PLACE, NE WASHINGTON, DC 20019	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1473	<p>Continued From page 17</p> <p>Friday. At the time of the medication administration, however, Resident #2 was not observed to receive the prescribed three drops of baby oil to both ears. The facility failed to ensure Resident #2's baby oil was administered without error.</p> <p>2. During the evening medication administration on September 30, 2009, at approximately 7:16 p.m., revealed Resident #4 received Haldol 2 mg, Dilantin 50 mg, Antacid 500 mg, and Amoxicillin 125 mg. Continued observation of the medication administration revealed the LPN crushed Resident #4's medications, mixed them with fruit butter and water, before administering.</p> <p>Review of Resident #4's medical record on October 1, 2009, beginning at approximately 10:15 a.m. revealed a Physician's Order (PO) dated September 2009. Review of the PO did not evidence that Resident #4's medication should be crushed. At the time of the survey, the facility failed to ensure Resident #4's medications were administered without error.</p> <p>3. During the evening medication administration on September 30, 2009, at approximately 7:16 p.m., Resident #4 received Haldol 2 mg, Dilantin 50 mg, Antacid 500 mg, and Amoxicillin 125 mg. The facility's LPN was observed to drop the Amoxicillin on the medication tray, proceeded to pick up the pill with her hand, and then placed it in a medication cup. Continued observation of the medication administration revealed the LPN crushed Resident #4's medications and at approximately 7:29 p.m., was observed to knock the cup of crushed medications over on the medication tray. She was observed to use a spoon to scoop the crushed medications back into a medication cup. Continuing to prepare the</p>	1473		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019		
(K4) 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)	(K5) COMPLETE DATE
1473	Continued From page 18 resident 's medications, the LPN was observed to mix the crushed medications with fruit buffer and water, after which she administered them to Resident #4. At the time of the medication administration, the facility failed to ensure Resident #4's medications were administered without error.	1473		
1500	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. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter for five of the seven individuals residing in the facility (Residents #2, #3, #4, #5 and #7). The findings include: 1. Section § 7-1305.05.d Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication [Formerly §§-1965] (d) Each customer shall have the right to a humane psychological and physical environment... Except when curtailed for reason of safety or therapy as documented in his or her record by a physician, he or she shall be afforded reasonable privacy in his sleeping and personal	1500	3523.1 This Statute will be met as evidenced by: Cross reference responses to W130, W140	11/9/09 On-going

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4918 EDSON PLACE, NE WASHINGTON, DC 20019		
(C4) 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)	(C5) COMPLETE DATE
1500	<p>Continued From page 19</p> <p>hygiene practices.</p> <p>[Cross refer to Federal Deficiency Report W130]. The facility failed to ensure Residents #3 and #6 right to privacy during personal care as evidenced below:</p> <p>Observation of the medication administration on September 30, 2009, beginning at approximately 7:16 p.m. revealed Resident's #3 and #6 received their medications in their bedroom. Resident #3 had just finished receiving a shower and was observed sitting in a shower chair naked with a bath towel draped over the front of her. During the administration of the medication, a male staff was observed to enter the resident's bedroom, without knocking first.</p> <p>Interview with the Assistant Director/Acting Qualified Mental Retardation (ADM/RP) on October 5, 2009, at approximately 6:00 p.m. revealed that the staff had been trained to knock on the resident's door before entering their rooms.</p> <p>At the time of the survey, the facility failed to ensure Residents #3 and #6 were provided privacy during personal care.</p> <p>2.. Section § 7-1306.05.g Visitors; mail; access to telephones; religious practice; personal possessions; privacy; exercise; diet; medical attention; medication [Formerly §6-1566] (g) Each customer shall have the right to prompt and adequate medical attention for any physical ailments...</p> <p>[Cross refer to 3520.3] The facility failed to ensure Resident's right to coordination of preventive health services.</p>	1500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(C2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(C3) DATE SURVEY COMPLETED 10/08/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, NE WASHINGTON, DC 20015		
(D4) 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)	(D5) COMPLETE DATE	
1500	Continued From page 20 3. The GHMR ^o failed to enact policies and/or procedures to ensure the theft of Resident #3's television was effectively addressed as identified below: On October 1, 2009 at 10:39 a.m., the review of an unusual incident report dated August 15, 2009 revealed a theft of Resident #3's large flat screen TV. A note on the incident report which was written by the facility's former Qualified Mental Retardation Professional (QMRP) revealed she checked the entire facility and stock rooms on August 17, 2009 in search of the resident's television, however did not find it. The incident report documented that the Administrator was notified of the incident on August 15, 2009. Further review of the incident report revealed the QMRP spoke with staff who worked on the night of August 14, 2009, to initiate an investigation. Interview with the Interim QMRP on October 1, 2009 at 10:50 a.m., revealed she was not working at the group home during the time the incident occurred. The QMRP stated, however, that it was the agency's policy to investigate such incidents. The QMRP stated that since the resident's TV had never been located after the incident, the agency should reimburse her for the value of the TV. At the time of the survey, there was no evidence a policy was in place to address the replacement or reimbursement of a resident's personal belongings in the event of theft. 4. [Cross Reference Federal Deficiency Report Citation W140] The facility's governing body failed to ensure the	1500			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0838	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4816 EDSON PLACE, NE WASHINGTON, DC 20010	

(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
1500	Continued From page 21 accurate accounting and record keeping of Residents #2, #3 and #4 financial records.	1500		