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

PRINTED: 03/01/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G123	A. BUILDING _____ B. WING _____	02/18/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from February 16, 2010 through February 18, 2010. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of six women with profound cognitive and intellectual disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that outside services met the needs of each client, for one of the three clients in the sample. (Client #3) The findings include: 1. On February 17, 2010, Client #3 ate lunch between 12:21 p.m. - 12:31 p.m. Throughout the meal, she leaned forward, with her back, neck and shoulders hunched over. Her face was situated at the edge of her plate, which had been placed on the table in front of her. Staff supervised and offered her intermittent assistance as needed throughout the meal. On February 18, 2010, at 4:33 p.m., review of Client #3's individual support plan (ISP), dated May 22,	W 120	W120 **This Standard will be met as evidenced by:** Client #3 mealtimes has been modified with specific guideline for mealtime observation and meal monitoring. This change has been discussed with client #3 day program speech pathologist. In addition, QMRP will revisit the day program to monitor meal to ensure compliance with mealtime protocol as prescribed. 2. Cross reference response to W249.2. The fall/prevention protocol will be reviewed with all staff. QMRP/Coordinator and LPN will continue to make routine visits to the day program, monitor staff interventions and provide follow-up as needed.	2-19-10 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DRS (X6) DATE: 3/10/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 2009, revealed the following: "She places her face close to the edge of her plate and requires verbal prompting to sit up when eating." Day program staff, however, failed to offer any verbal prompts for her to sit up during lunch, in accordance with her ISP. 2. Cross-refer to W249.2. On February 17, 2010, a day program staff person reached behind Client #3, took hold of the waistband above her buttocks and began pulling upwards to assist her in standing up from a reclining chair. In the facility, interviews with the house manager, the daytime licensed practical nurse (LPN) and the acting qualified mental retardation professional (AQMRP) revealed that staff should not lift the client by her waistband. Review of the client's fall prevention protocol, dated January 12, 2010, provided confirmation. It should be noted that the AQMRP stated that the Physical Therapist (PT) had conducted a recent in-service training for day program staff. There was no evidence, however, that staff consistently assisted Client #3 in accordance with her fall prevention protocol.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that	W 124		

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W 124	Continued From page 2 would ensure clients, family members or guardians were informed of their risks and benefits of clients restrictive measures, for the two clients in the sample with restrictive behavior support plans (out of a three-person sample). (Clients #2 and #3) The findings include: 1. The facility failed to ensure that informed consent was obtained from Client #2's guardian prior to the implementation of her behavior support plan (BSP), dated March 27, 2009, that included the use of psychotropic medications. During the entrance conference on February 16, 2010, at 10:19 a.m., the registered nurse (RN) and facility manager indicated that Client #2 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Interview with the license practical nurse (LPN) on February 16, 2010, during the evening medication pass at 7:29 p.m., revealed that Client #2 received her psychotropic medications during the morning medication administration. The RN's statement was verified on February 17, 2010, at 2:20 p.m., through review of Client #2's psychological assessment dated January 21, 2010. According to the assessment, Client #2 "can not make independent decisions on her own behalf regarding her habilitation planning, residential placement, treatment, medical, and financial matters". Interview with the acting qualified mental retardation professional on	W 124		

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W 124	Continued From page 3 February 17, 2010, at approximately 2:00 p.m., revealed that the client had a court appointed guardian who is involved in her habilitation planning and decision making process. At the time of the survey however, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication. 2. Similarly, there was no evidence that the facility reviewed Client #3's medical condition and her treatment plan, including prescribed medications, with her medical guardian, as follows: During the Entrance Conference on February 16, 2010, at approximately 11:10 a.m., the RN and facility coordinator indicated that Client #3 had a court-appointed guardian and was prescribed psychotropic medications. This was later verified through record review. Later that day, at 7:53 p.m., Client #3 was administered Risperdal and Naltrexone Hydrochloride during the evening medication administration pass. Interview with the LPN during the medication pass confirmed that the aforementioned medications were used to address the client's behaviors. On February 18, 2010, at 5:57 p.m., review of Client #3's records failed to show evidence that the medical guardian had received a review of the potential benefits and risks of the client's medication regimen and provided written consent. The acting qualified mental retardation professional stated that she would contact the guardian to request documentation. No additional information, however, was made available.	W 124	W124 **This Standard will be met as evidenced by:** Informed consent for client #2 and client #3 has been updated by the designated guardians. The QMRP will ensure that individuals and their representatives are made aware of treatment therapies, medications as well as risks and benefits. Further, legally authorized representative will be updated whenever changes occur and prior to administration of psychotropic medications.	3/5/10
W 137	483.420(a)(12) PROTECTION OF CLIENTS	W 137		

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W 137	Continued From page 4 RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients had clothing that was the appropriate size, for one of the three clients in the sample. (Client #2) The finding includes: Observations conducted at Client #2's day program on February 16, 2010, at 1:13 p.m., revealed Client #2 walking into her classroom wearing a brown shirt that was too small. Further observation revealed that the lower part of her stomach was exposed and her sleeves were too short Interview with the day program case manager on February 16, 2010, at 1:30 p.m., revealed the facility frequently sent Client #2 to the day program wearing clothes that were either too big or too small. Day program reportedly had conveyed their concern to the facility. Record review on February 17, 2010, at approximately 11:00 a.m., revealed the day program and the facility held a case conference on January 14, 2010. At the meeting, the day program case manager requested that the facility purchase a "new jacket, hat, scarf, and other clothing" for the client. On February 17, 2010, at approximately 4:00 p.m., interview with the acting	W 137	**W137** **This Standard will be met as evidenced by:** Inventory of client #2 clothing showed that she has adequate supply of clothing that is appropriate for the weather. All staff will received additional training on expectations "appropriate fitting clothing" that is appropriate for the weather. QMRP and Home manager will continue on-going monitoring of individuals to ensure compliance with this standard as set forth.	3/11/10 On-going

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W 137	Continued From page 5 qualified mental retardation professional (AQMRP) revealed the facility had purchased new clothes since the case conference. It remained unclear, however, why the client was sent to day program on February 16, 2010, with a poor-fitting shirt. There was no evidence that the facility ensured that Client #2 wore appropriate fitting clothing.	W 137		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff consistently implemented policies developed to protect client safety, for three of the six residents of the facility. (Clients #2, #3 and #6) The findings include: 1. Based on observation, interview and record review, facility staff failed to implement the policy on transportation safety, as detailed below: a. On February 16, 2010, at 9:14 a.m., observations revealed that facility staff failed to ensure that Clients #2, #3 and #6's seat belts were properly secured prior to being transported in the facility's van, in accordance with District of Columbia law and facility policies. Once the observation was brought to the facility coordinator's attention by the surveyor, she instructed the staff to assist in securing their	W 149	W149 **This Standard will be met as evidenced by:** QMRP/Home Manager will implement appropriate follow-up to include disciplinary action and training. All staff assigned to the home have participated in driving training courses and are aware of the policies and procedures related to vehicle safety. QMRP and home manager will continue to provide on-going monitoring of drivers/attendance to ensure compliance with safety rules.	3/1/10 ongoing

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W 149	Continued From page 6 seatbelts. b. On February 16, 2010, at 8:41 a.m., observations revealed that facility staff again failed to ensure that Clients #2, #3 and #6's seat belts were properly secured in the facility's van. On February 18, 2010, beginning at 3:39 p.m., review of Chapter VI, Section 5, of the facility's safety policies ("Transporting Customers") revealed the following: "Seat belts are to be worn at all times during the transportation process and will be checked to see that the belts are fastened before the vehicle begins the trip." Review of the driver safety training materials revealed that the QMRP and facility coordinator were responsible for ensuring vehicle safety.	W 149		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility staff and day program staff failed to consistently implement the fall prevention protocol as prescribed, for the one client in the sample with such a protocol. (Client #3) The findings include: 1. On February 16, 2010, from 7:26 a.m. - 7:41 a.m., a direct support staff person (S1) was observed assisting Client #3 at breakfast. At 7:42 a.m., the client began to raise herself from her seat. S1 reached behind the client, took hold of	W 194	W194. This Standard will be met as evidenced by: Additional trainings was provided by the PT both at the home and the day program staff on Lifting and transferring to include the walking protocol for client #3. In addition, QMRP/Home Manager will continue to monitor staff to ensure that they are implementing the protocol, and consistently demonstrating the skills and techniques as outlined.	3/1/10 ongoing

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W 194	Continued From page 7 the waistband above her buttocks and began pulling upwards. Once standing, S1 positioned herself behind Client #3, placed her hands to either side of the client's waist and held that position as they walked together for approximately 12 feet. The client then sat down on the love seat in the living room. 2. On February 17, 2010, at 12:30 p.m., a direct support staff person at Client #3's day program responded when the client expressed her wish to use the restroom. The client was seated in a recliner at the time. The staff person reached behind the client, took hold of the waistband above her buttocks and began pulling upwards. Once standing, the client left the room with the staff. During the Entrance Conference on February 16, 2010, at 10:50 a.m., the facility coordinator and the LPN assigned to the 8:00 a.m. - 4:00 p.m. shift stated that the physical therapist (PT) had trained staff recently on how to assist Client #3. They described and demonstrated techniques to be used when assisting the client to a standing position and with ambulation. Staff were to walk along the client's left side, placing their right hand around the client's lower back to her waist, and their left hand at the client's front left trunk. Staff were not to hold the client's pants and were not to walk behind the client. Before leaving Client #3's day program the following afternoon, at approximately 1:10 p.m., review of her fall prevention protocol, dated January 12, 2010, confirmed that the house manager and LPN had accurately described the techniques prescribed by the PT. Upon return to the facility, the acting qualified mental retardation	W 194		

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W 194	Continued From page 8 professional described the fall prevention techniques and confirmed that staff should not lift the client by her waistband. She further stated that the fall prevention protocol was incorporated in Client #3's individual support plan, and that the PT had conducted a recent in-service training for day program staff. There was no evidence, however, that staff in the home and at day program consistently implemented Client #3's fall prevention strategies as written.	W 194		
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, interview and record review, facility staff and day program staff failed to consistently implement the fall prevention protocol as prescribed, for the one client in the sample with such a protocol. (Client #3) The findings include: 1. On February 16, 2010, from 7:26 a.m. - 7:41 a.m., a direct support staff person (S1) was observed assisting Client #3 at breakfast. At 7:42 a.m., the client began to raise herself from the her seat. S1 reached behind the client, took hold of	W 249	W249 This Standard will be met as evidenced by: Reference response to W194.	3.11.10 ongoing

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W 249	Continued From page 9 the waistband above her buttocks and began pulling upwards. Once standing, S1 positioned herself behind Client #3, placed her hands to either side of the client's waist and held that position as they walked together for approximately 12 feet. The client then sat down on the love seat in the living room. 2. On February 17, 2010, at 12:30 p.m., a direct support staff person at Client #3's day program responded when the client expressed her wish to use the restroom. The client was seated in a recliner at the time. The staff person reached behind the client, took hold of the waistband above her buttocks and began pulling upwards. Once standing, the client left the room with the staff. During the Entrance Conference on February 16, 2010, at 10:50 a.m., the facility coordinator (aka house manager) and the LPN assigned to the 8:00 a.m. - 4:00 p.m. shift stated that the physical therapist (PT) had trained staff recently on how to assist Client #3. They described and demonstrated techniques prescribed for transferring the client to a standing position and with ambulation. Staff were to walk along the client's left side, placing their right hand around the client's lower back to her waist, and their left hand at the client's front left trunk. Staff were not to hold the client's pants and were not to walk behind the client. Before leaving Client #3's day program the following afternoon, at approximately 1:10 p.m., review of her fall prevention protocol, dated January 12, 2010, confirmed that the house manager and LPN had accurately described the techniques prescribed by the PT. Upon return to	W 249		

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W 249	Continued From page 10 the facility, the acting qualified mental retardation professional described the fall prevention techniques and confirmed that staff should not lift the client by her waistband. She further stated that the fall prevention protocol was incorporated in Client #3's individual support plan, and that the PT had conducted a recent in-service training for day program staff. There was no evidence, however, that staff in the home and at day program consistently implemented Client #3's fall prevention strategies as written.	W 249		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consent was obtained from the clients' guardian and/or surrogate healthcare decision-maker, for two of the three clients in the sample. (Client #2 and #3) The findings include: 1. During the entrance conference on February 16, 2010, at 10:19 a.m., the registered nurse (RN) indicated that Client #2 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to	W 263	W263 **This Standard will be met as evidenced by:** Reference W124. In addition, programs the HRC will review and ensure that informed consents for each individual has been obtained prior to implementation of programs or practices which may involve risks or compromise the individual's protections or rights. HRC Chairperson will maintain master listing of all individual's who require restrictive interventions and dates reviewed by HRC. Routine reviews will be completed to further ensure compliance with this standard.	3/5/10 ongoing

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W 263	Continued From page 11 give informed consent for the use of medications and habilitation services. On February 17, 2010, at approximately 2:00 p.m., the acting qualified mental retardation professional (AQMRP) also indicated that the client lacked capacity to give informed consent. She then stated that the client had a court-appointed medical guardian who provided substituted consent for health care decisions. On February 17, 2010, beginning at 2:20 p.m., review of Client #2's psychological assessment, dated January 21, 2010, revealed that she could not "make independent decisions on her own behalf regarding her habilitation planning, residential placement, treatment, medical, and financial matters." Client #2's behavior support plan (BSP), dated March 27, 2009, confirmed that the plan incorporated the use of psychotropic medications (Prozac and Atarax). Further review of the client's record that afternoon failed to show evidence that the facility had obtained written consent for the BSP (and/or medications) from Client #2's guardian. 2. Cross-refer to W124.2. Similarly, Client #3's BSP, dated July 31, 2009, incorporated the use of Risperdal and Naltrexone Hydrochloride. On February 18, 2010, at 5:50 p.m., review of the client's record revealed no evidence of written consent from the client's medical guardian. The acting qualified mental retardation professional stated that she would contact the guardian to request documentation. Review of the facility's Human Rights Committee documents failed to show evidence that the committee had sought written consent for the BSP (and/or medications) from Client #3's guardian. No additional	W 263		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G123		02/18/2010

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

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W 263	Continued From page 12 information was made available before the survey ended.	W 263		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for one of the six clients residing in the facility. (Clients #5) The finding includes: Observation of the medication administration on February 16, 2010, at 6:28 p.m., revealed Client #5 was administered Lubrifresh eye ointment for dry eyes. Review of the of the medication administration forms and the physician order dated December 1, 2010, revealed that the client should have received the Lubrifresh at 4:00 p.m., 2 1/2 hours earlier. When interviewed, the LPN confirmed the timing error, and acknowledged that he had administered the Lubrifresh at 6:23 p.m. (after having spoken with the client's primary care physician).	W 368	W368 **This Standard will be met as evidenced by:** Cross reference response to 369.	3.5.10 ongoing
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 369		

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W 369	Continued From page 13 review, the facility failed to ensure that medications were administered without error, for two of the six clients residing in the facility. (Clients #1 and #3) The findings include: 1. Observation of the medication administration on February 16, 2010, at 7:53 p.m., revealed Client #3 was administered Keppra, Revia, Trileptal, Calcium, Coreg, Risperdal, Vitamin E Capsule, Cranberry and Enulose. On February 17, 2010, at 9:30 a.m., review of the client's medication administration record (MAR) and the physician orders dated December 1, 2009, revealed that a nitroglycerin patch had been placed on the client's lower chest wall at 7:00 a.m. The nitroglycerin patch was scheduled to be removed at 7:00 p.m. Interview with the LPN on February 17, 2009, at approximately 4:30 p.m., revealed that the patch was taken off after 9:00 p.m. There was no evidence that the LPN removed the nitroglycerin patch as prescribed by the physician. 2. On February 16, 2010, at 8:37 p.m., Client #1 was administered Phenobarbital, Mucinex, Tegretol, Senna, Polyethylene Glycol, Enulose and Valproic Acid. On February 17, 2010, at 9:30 a.m., review of the client's MAR and the physician orders dated December 1, 2009, revealed Nasonex 1 spray in each nostril (twice daily) also should have been administered that evening. The LPN, however, was not observed to administer the Nasonex as prescribed.	W 369	W369 **This Standard will be met as evidenced by:** RN will continue to monitor nursing interventions and medication administration. RN will document observations and provide immediate training as needed if problems are identified during the medication administration process. RN will also complete competency reviews at the time of hire and ongoing thereafter to further ensure compliance with this standard.	3/10 ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed	W 436		

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

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W 436	Continued From page 14 choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain clients' adaptive beds in functioning condition, for three of the six clients residing in the facility. (Clients #2, #4, and #6) The findings include: During the environmental inspection on February 18, 2010, beginning at 4:05 p.m., Client #2's and Client #6's hospital beds were inoperable. A few minutes later, interview with the house manager revealed that the electrical sockets needed repair. 2. At approximately the same time, Client #4's hospital bed was inoperable. The house manager tried to change the mattress position; however, the control apparatus did not respond. She could not determine why the bed was not functioning properly. There was no evidence that the facility ensured the use of all adaptive beds.	W 436	W436. **This Standard will be met as evidenced by:** 1&2. The facility maintenance crew has repaired client #2, #4 and #6 socket. The bed is now operating without any problems. QMRP/Home Manager complete weekly environmental and equipment checklists. Identified problems are addressed with the Maintenance Department and/or vendor.	2.19.10 ongoing
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 448		

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	09G123		02/16/2010

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

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W 448	Continued From page 15 failed to provide evidence that ensured problems with evacuation drills were investigated and addressed. The finding includes: Review of the facility's evacuation drill records on February 16, 2010, beginning at 3:55 p.m., revealed the design of the evacuation drill records included a place for the signature of the person that completed the drill and required the signature of the person that reviewed the drill record. Review of the evacuation drills from the period January 7, 2009 - February 16, 2010, failed to show evidence that the drills records had been reviewed. Further review of the drill records revealed that in the 3-month period of January 1, 2009 - March 31, 2009, 14 of the 16 documented evacuations conducted were achieved within 10 minutes or less. Drill records for the 10 months that followed revealed similar time frames. There were a few drills, however, that were documented as taking significantly longer. For example, a drill on January 7, 2009 reportedly took 15 minutes to complete. Another drill conducted on December 3, 2009 was documented as taking 20 minutes. The facility coordinator (aka house manager) was interviewed on February 16, 2010, beginning at 5:07 p.m. She stated that it was her role and responsibility to review the records. She then acknowledged that there was no evidence the evacuation drill records from January 7, 2009 - February 16, 2010, had been reviewed. When asked about the 20-minute drill on December 3, 2009, she exclaimed "It should not take that long!" and then added that she was previously	W 448	W448 **This Standard will be met as evidenced by:** Additional training was provided to Facility Coordinator on monitoring of fire drills. In addition, all staff also received training on fire drill including safe amount of time for persons to exit from the facility in case of a fire. The Facility Coordinator will continue to provide on-going monitoring of fire drills as evidenced by her signature on each drill as file in the fire drill book.	3.19.10 Ongoing

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W 448	Continued From page 16 unaware. The acting qualified mental retardation professional (AQMRP) arrived in the facility a few minutes later. At 5:22 p.m., after being asked if management had determined the length of time it should take to safely evacuate the facility, she said their fire safety expert had stated during staff in-service training that "anything beyond 10 minutes could be lethal... they will be dead... smoke inhalation." When asked about drills taking 15 or 20 minutes to complete, she said that should trigger an investigation and additional staff training. She confirmed that it was the facility coordinator's responsibility to review drill/evacuation records and report problems to management. The AQMRP further indicated that she was previously unaware.	W 448		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/18/2010
NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE: 431 53RD STREET, SE WASHINGTON, DC 20019		

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I 000	INITIAL COMMENTS A licensure survey was conducted from February 16, 2010, through February 18, 2010. A sample of three residents was selected from a population of six women with profound cognitive and intellectual disabilities. The findings of the survey were based on observations, interviews with residents and staff in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 049	3502.7 MEAL SERVICE / DINING AREAS Each GHMRP shall serve meals at proper temperatures. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to properly prepare the residents dinner for six of the six residents in the facility. [Residents #1, #2, #3, #4, #5, #6] The finding includes: During the environmental inspection on February 18, 2010, beginning at 4:05 p.m., revealed a tray of cooked chicken breast on the stove. Further observation revealed that the chicken was not on a warmer. Interview with the acting qualified mental retardation professional revealed that the direct support staff had taken the chicken out of the oven at 3 p.m. Further interview revealed that the residents were scheduled to eat between 5 p.m., and 6 p.m. The Qualified Mental Retardation Professional (QMRP) failed to ensure that the residents meal was kept at an appropriate temperature.	I 049	3502.7 Meal Service/Dining Areas This Statute will be met as evidenced by: The QMRP has conducted training for all staff on proper food storage and appropriate temperatures. The Home Manager, QMRP and LPN staff will monitor food preparation process on an ongoing basis, provide feedback and direction for staff as needed and schedule Nutritional training if needed.	2-19-10 ongoing

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Branch

TITLE: DRS

(X6) DATE: 3/10

STATE FORM

B11611

If continuation sheet 1 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-6035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/18/2010
NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE: 431 53RD STREET, SE WASHINGTON, DC 20019		

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I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the Group for Mentally Retarded Persons (GHMRP) governing body failed to document a review of its policies and procedures annually. The findings include: On February 18, 2010, at approximately 3:05 p.m., review of the policy and procedure manual that was maintained in the home, failed to provide evidence that the agency had reviewed and approved its policies at least annually. The most recent documented review was in 2008. The acting qualified mental retardation professional (AQMRP) presented another manual that she said she carried with her at all times. That manual also did not reflect a review since 2008. The AQMRP quickly telephoned their corporate office and at 3:10 p.m., she stated that the agency's policies had been reviewed in March 2009. She did, however, acknowledge that said review had not been documented in either manual that was available for review.	I 161	3507.2 Policies and Procedures **This Statute will be met as evidenced by:** The policy and procedures manuals have been reviewed, updated and signed. Annual review of the manuals will continue to occur to maintain compliance with this statute.	7/2/10 ongoing
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and...	I 186		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/18/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019		

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I 186	Continued From page 2 This Statute is not met as evidenced by: Based on review of the organizational chart that was presented, the Group for Mentally Retarded Persons (GHMRP) failed to ensure that the organizational chart showed the numbers of supportive and direct care staff. The findings include: 1. On February 18, 2010, at 2:55 p.m., the acting qualified mental retardation professional (AQMRP) presented two organizational charts (not dated). Review of the two charts revealed that neither one showed the number of direct support staff employed by the GHMRP. 2. Further review of the organizational charts revealed that neither chart indicated the number of LPNs and/or medication nurses employed by the GHMRP. At 2:58 p.m., the AQMRP acknowledged that the organizational charts did not indicate the numbers of nursing and direct support staff.	I 186	**This Statute will be met as evidenced by:** 1. The Organizational charts have been filed into the book for review. The Human Resources Department will continue to update and file organizational charts and update whenever changes occur. 2. Reference response to #1.	2.19.10 ongoing
I 206	3509.8 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group for Mentally Retarded Persons (GHMRP) failed to	I 206		

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I 206	Continued From page 3 have on file for review, current health inventories/certificates for 2 of the 10 licensed consultants working with the three residents in the sample. (Residents #1, #2 and #3) The findings include: On February 18, 2010, beginning at approximately 12:10 p.m., review of the personnel records maintained for professional consultants and interview with the acting qualified mental retardation professional (AQMRP) revealed, no evidence of a physician's certification/ health inventory for the speech pathologist and occupational therapist. No additional information was provided before the survey ended later that day. This is a repeat deficiency. Previously, the December 12, 2008 deficiency report included the following: "Interview with QMRP and review of the personnel records on November 5, 2008 revealed the GHMRP failed to have evidence of physical examination for the following; the Program Director, two LPN's, the Speech Pathologist and the Pharmacist."	I 206	1206 3509.6 This Statute will be met as evidenced by: The consultant files are maintained in one book for review. Based on record review the certification/health inventories have been filed in the record for the Speech Therapist and Physician. The OT consultant services have been discontinued until required documents are received. The Administrative Assistant or designee will establish a master of all expiration dates and send notices at least 90-days in advance to alert the individual consultant of the required needs. This information will be filed immediately upon receipt and made available for review.	4.19.10 ongoing
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by:	I 274		

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I 274	Continued From page 4 Based on interview and record review, the Group for Mentally Retarded Persons (GHMRP) failed to have on file for review, current written agreements or contracts for 2 of the 10 licensed consultants working with the three residents in the sample. (Residents #1, #2 and #3) The findings include: On February 18, 2010, beginning at approximately 12:10 p.m., review of the personnel records maintained for professional consultants and interview with the acting qualified mental retardation professional revealed no evidence of written agreements or contracts between the GHMRP and the physical therapist and podiatrist. No additional information was provided before the survey ended later that day.	I 274	1274 3513.1(e.) Administrative Records **This Statute will be met as evidenced by:** The contract agreement for the Podiatrist will be re-done as the original document can not be found. The Physical Therapist's contract agreement between Individual Development Inc. and Innovative Rehabilitation, Inc. the consultant can assign or delegate specific tasks or duties. However they must have professional qualifications, licenses and certifications necessary or required by law to render the service.	2-28-10 going