

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G129	(X2) MULTIPLE BUILDING SURVEY A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/03/2010
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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W 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18886 A recertification survey was conducted from February 22, 2010, through March 3, 2010. The survey was initiated using the fundamental survey process; however, due to information obtained from the personnel records, the survey was extended under the Condition of Participation in Client Protections. A random sample of two clients was selected from a population of four male clients with various levels of mental retardation and disabilities.</p> <p>The findings of the survey was based on observations at the group home and one day program, interviews with the clients and staff, and the review of clinical and administrative records including incident reports.</p> <p>Based on the findings, the facility failed to meet the compliance requirements in the Condition of Participation in Client Protections.</p>	W 000		
W 122	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Surveyor: 18886 Based staff interviews and record reviews the facility failed to implement policies and procedure to ensure the health and safety of each client [See W149]; and failed to prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment[See W152].</p>	W 122	<p><b>W122</b></p> <p><b>This CONDITION will be met as evidenced by:</b></p> <p><b>The facility did not hire an employee with a conviction or prior employment history of child or client abuse, neglect or mistreatment.</b></p> <ul style="list-style-type: none"> <li><b>(W149) The facility has written policies and procedures that prohibit mistreatment, neglect or abuse of all persons. The policies will be reviewed and modified to provide greater accountability. The Director of Human Resources will continue obtain background checks for all applicants prior to employment and/or prior to being assigned to the group home. The facility has established a QA review process whereby the Incident Manager/QA will review personnel records on a monthly basis. Verification of</b></li> </ul>	3.12.10 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 3	(X6) DATE 4.7.10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1	W 122	<p><b>record reviews will be maintained in the personnel book for review. Deficient practices will be reported immediately to the CEO and Senior Managers and appropriate corrective actions are taken immediately to address systemic and deficient practices.</b></p> <ul style="list-style-type: none"> <li><b>(W152)The Human Resource Director will file all documentation to support follow-up actions/investigation of the background checks (if warranted). Documentation shall include but not limited to; sworn statements, subsequent background checks, and any other document to support actions taken by the facility. The Human Resource Director will also conduct random background checks to include an annual sampling up to 10% of the employee roster.</b></li> </ul>	
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18886 Based on interview and record review, the facility failed to implement policies and procedures to ensure the health and safety of four of four clients residing in the facility. (Client #1, #2, #3, and #4)</p> <p>The finding includes:</p> <p>(Cross Reference W152). The facility failed to ensure the development/implementation of policies that prohibit the employment of individuals that have been convicted of child abuse, neglect or mistreatment, as evidenced below:</p> <p>Review of staff personnel records on February 22, 2010, beginning at 4:55 p.m., revealed one of the ten staff, providing direct services to the clients, had a criminal background check that indicated he was a "sex offender (Staff #3)." Further review of the background check revealed that Staff #3 had failed to register with the sex offender registry on February 23, 2006. Interview with the Program Director (PD) on February 22, 2010, at 5:30 p.m., revealed that the staff person was still on the current schedule. The PD called the Human Resources (HR) office on February</p>	W 149		

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W 149	<p>Continued From page 2</p> <p>22, 2010, at approximately 5:30 p.m., and was informed that the staff person told the HR department, "that is not me," when questioned about the criminal background check disposition. On February 23, 2010, at approximately 11:00 a.m., the PD gave the surveyor notification that the staff had been removed from the schedule.</p> <p>Review of the facility personnel policy on February 23, 2010, at approximately 3:00 p.m., revealed that a police clearance must be obtained prior to employment. At the time of the survey, however, the facility failed to investigate the disposition documented on Staff #3's police clearance in order to verify that the staff was suitable to be employed.</p>	W 149	<p><b>W149</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p><b>Reference response to W122.</b></p>	3.12.10 ongoing
W 152	<p>483.420(d)(1)(iii) STAFF TREATMENT OF CLIENTS</p> <p>The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18886 Based on interview and the review of employee records, the facility failed to prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment, for one of ten staff. (Staff #3)</p> <p>The finding includes:</p> <p>(Cross Reference to W149). Review of the facility's personnel records on February 22, 2010,</p>	W 152	<p><b>W152</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p><b>Reference response to W122.</b></p>	3.12.10 ongoing

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W 152	<p>Continued From page 3</p> <p>beginning at 4:55 p.m., revealed Staff #3 had a criminal background check that reflected "Registered Sex Offender". Further review of the background check, revealed the staff's failure to register on February 23, 2006. Interview with the Program Director (PD) on February 22, 2010, at 5:30 p.m., revealed the staff person was currently employed and was working on the current schedule. The PD called the Director of Human Resources (DHR) on February 22, 2010, at approximately 5:30 p.m., and was informed that the staff person had told them, "I am not that person." On February 23, 2010, at approximately 11:00 a.m., the PD presented notification to the surveyor that revealed Staff #3 had been removed from the schedule as of February 23, 2010.</p> <p>The DHR revealed that although she obtained a background check on Staff #3, on September 20, 2009, the disposition of the check indicated that the identified person was a "sex offender" on February 23, 2006. She further stated that she had not had the opportunity to check into this matter, any further, but had plans to fully investigate.</p> <p>There was no evidence that the facility investigated the disposition of the criminal background check prior to Staff #3 beginning his employment.</p>	W 152		
W 212	<p>483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.</p> <p>This STANDARD is not met as evidenced by:</p>	W 212	<p><b>W212</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p><b>The QMRP will follow-up with the Psychiatrist to obtain an updated assessment to ensure total clarification. The psychiatrist continues to review the client #1's status on a monthly basis.</b></p>	<p>4.7.10 ongam</p>

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W 212	<p>Continued From page 4</p> <p>Surveyor: 18886</p> <p>Based on observation, staff interview and record review, the facility failed to ensure that each client who received psychotropic medications had a psychiatric assessment, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observation of the morning medication administration on February 22, 2010, at 8:05 a.m., revealed Client #1 received Fluphenazine Hydrochloride. Interview with the licensed practical nurse (LPN) on February 22, 2010, during the medication administration, indicated that the medication was prescribed for behavior management.</p> <p>Review of the client's physicians orders dated February 2010, on February 22, 2010, at 10:30 a.m., revealed that the aforementioned medications were incorporated in a Behavior Support Plan (BSP) dated June 22, 2009. Continued review of the orders revealed that the aforementioned medication was used to treat his diagnosis of schizophrenia. This information was verified through the review of the client's psychological assessment dated July 2, 2009.</p> <p>Client #1's medical evaluation dated July 6, 2009, on February 22, 2010, at approximately 10:50 a.m., the evaluation consumed that the the psychotropic medications were prescribed to address behaviors associated with a diagnosis of schizophrenia.</p> <p>Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.</p>	W 212		4.7.10 ongoing

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W 255	<p><b>483.440(f)(1)(i) PROGRAM MONITORING &amp; CHANGE</b></p> <p>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 has successfully completed an objective or objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18886 Based on interview and record review, the facility's qualified mental retardation professional (QMRP) failed to provide evidence that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective, for two of the two clients included in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. The QMRP failed to revise Client #1's IPP once he met the established criteria.</p> <p>Review of Client #1's IPP dated July 6, 2009, on February 23, 2010, at approximately 2:10 p.m., revealed the following program objectives:</p> <p>- "With verbal prompting, [the client] will complete the steps of making his bed on 100% of the trials for the month, for six consecutive months as measured by active treatment documentation."</p> <p>Record verification of the data sheets, revealed that the client met the established criteria since June 2009.</p> <p>- "With verbal prompting, [the client] will complete</p>	W 255	<p><b>W255</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p><b>Program objectives for client #1 will be reviewed and revised as needed. A new QMRP has been assigned to the home and will oversee and address all program issues. Routine audits will also be completed by DRS and/or designees, additional training and direction will be provided to the QMRP as warranted.</b></p>	<p>4/7/10 ENDING</p>
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W 255	Continued From page 6 the steps of vacuuming the carpet in the basement area on 80% of the trials recorded for the month for six consecutive months as measured by active treatment documentation."  Record verification of the data sheets, revealed that the client met the established criteria since November 2009.  Interview conducted with QMRP at the same time, verified that the aforementioned programs had not been revised once he met the established criteria.  b. Review of Client #2's IPP dated June 30, 2009, on February 23, 2010, at approximately 10:00 a.m., revealed the following program objectives:  Review of Client #2's IPP dated June 30, 2009, revealed a program objective which stated, "Given verbal prompts, [the client] will brush his teeth and gums with a battery operated tooth brush 80% of the trials". Review of the QMRP monthly notes dated from August 2009 through January 2010, revealed the client was independent or required verbal prompts since September 2009.  There was no evidence that the QMRP revised the program (tooth brushing).	W 255			
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.	W 325			

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W 325	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18886 Based on staff interview and record verification, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for one of the two clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Review of Client #1's medical record on February 23, 2010, beginning at 9:47 a.m., revealed a physician order dated February 2010, for annual liver function test (LFT) and renal function test (RFT). Record verification revealed no evidence of either a LFT or RFT.</p> <p>Interview with the Licensed Practical Nurse on the same day, confirmed that there were no laboratory studies.</p>	W 325	<p><b>W325</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p>The LFT and renal function test (RFT) was completed on 1.16.10. This information was shared with the surveyor at the time of the exit review when this concern was raised. (See attached documentation) Routine laboratory screenings continue to be monitored by the nurse assigned to the home and implemented as ordered.</p>	3.4.10 <i>ongoing</i>
W 336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18886 Based on interview and record review, the facility failed to ensure that each client's health status was reviewed by a Registered Nurse (RN) on a quarterly or more frequent basis, one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p>	W 336	<p>RN will continue to review laboratory schedules for all persons and update laboratory schedules as needed/recommended by the PCP for all persons residing at this location.</p> <p><b>It should further be noted that prior to the exit the Nurse Practitioner verified with the surveyor that the renal and liver function test had been completed.</b></p> <p><b>IDI respectfully request that this deficiency be removed.</b></p>	

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W 336	Continued From page 8  Review of Client #1's medical record on February 23, 2010, at 9:47 a.m., revealed a quarterly nursing assessment dated October 2009. Further review of the client's record, however, revealed no further quarterly assessment had been performed. Interview with the RN on February 23, 2010, revealed at approximately 1:00 p.m., the RN acknowledged that the quarterly assessment was due in January 2010.	W 336	W336  <b>This Standard will be met as evidenced by:</b>  Client #2's nursing quarterly has been completed. The RN will ensure that quarterly reviews are performed within the month in which the quarter ends. The DON and/or designees will conduct random reviews and monitor individual's status to ensure that quarterly assessments (or more frequent dependent on the persons need) are completed and available	4.1.10 ongoing
W 371	483.460(K)(4) DRUG ADMINISTRATION  The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.  This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record review, the facility failed to implement an effective system to ensure each client participated in a self-medication program, for two of the two clients in the sample. (Clients #1 and #2)  The findings include:  1. Observation during the morning medication observation, on February 22, 2010, at 8:25 a.m., the licensed practical nurse (LPN) was administering client #1 his medications by punching the medications from the bubble pack, providing hand over hand assistance to Client #1 with pouring a cup of water and handing the medication cup to the client. The client consumed the pills and drank the water with	W 371		

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W 371	<p>Continued From page 9 verbal prompts.</p> <p>Interview with the LPN, after the medication pass, revealed the client did not participate in a self-medication training program. Review of the record revealed no self medication assessment. However, Client #1 was observed pouring liquid into cups, during his meals, independently, and reading the newspaper.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated July 6, 2009, on February 23, 2010, at approximately 11:00 a.m., revealed no program goal or objective for the client to receive training in self-medication skills development.</p> <p>2. On February 22, 2010, at 8:05 a.m., Client #2 was observed during his medication administration. The LPN was observed punching all the client's medication from the bubble packs, pouring a cup of water and giving them to the client. The client consumed his medications with many verbal prompts.</p> <p>Interview with the LPN, after the medication pass, revealed the client did not participate in a self-medication program. Review of the record revealed no self medication assessment. Review of Client #2's Individual Program Plan (IPP) dated July 30 2009, on February 22, 2010, at approximately 2:00 p.m., revealed no program goal or objective for the client to receive training in self-medication skills development.</p>	W 371	<p><b>W371</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p><b>All individuals are assessed on an annual basis and/or as recommended by the IDT in order to determine the persons abilities and needs in the area of self medication administration. Individual training programs are developed based on the assessment and discussion from the IDT. Self medication assessments will be reviewed and updated as needed and formal program plans developed based on the persons functional abilities.</b></p>	4-6-10 ONGP/IN
W 381	<p><b>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING</b></p> <p>The facility must store drugs under proper conditions of security.</p>	W 381		

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W 381	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation and record review, the facility's nurse failed to remove from use, out dated medications, for one of four clients residing in the facility. (Client #3)</p> <p>The findings include:</p> <p>On February 23, 2010, beginning at 2:20 p.m., during an environmental inspection, a jar of hydrocerin cream was observed on Client #3's dresser. The label on the jar had an expiration date of May 9, 2009. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired.</p> <p>At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medications were removed from the clients' supplies after the expiration date.</p>	W 381	<p><b>W381</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p>DON/RN will complete additional training for LPN staff assigned to the home. All expired creams and medications have been removed from client #3's room. The nurse continues to store all medications in a secured closet. The RN will check all medications on a routine basis and take corrective actions when needed. DON will complete random QA reviews to further ensure compliance with this standard.</p>	3/26/10 original
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## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/03/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL DEVELOPMENT, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 WALNUT STREET, NE WASHINGTON, DC 20018</b>		
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I 000	<b>INITIAL COMMENTS</b>  A licensure survey was conducted from February 22, 2010, through February 23, 2010. A random sample of two residents was selected from a population of four male residents with various levels of mental retardation and disabilities.  The findings of the survey was based on observations at the group home and one day program, interviews with the clients and staff, and the review of clinical and administrative records, including incident reports.	I 000		
I 090	<b>3504.1 HOUSEKEEPING</b>  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the interior of the GHMRP was maintained in a clean, orderly, attractive, and sanitary manner, for four of four residents included residing in the facility. (Residents #1, #2, #3, and #4)  The findings include:  An environmental inspection conducted on February 23, 2010, beginning at 2:20 p.m. revealed the following:  1. The chandelier located in the dining room was dirty and dusty. Several light bulbs were inoperable.	I 090		

Health Regulation Administration

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

STATE FORM

6822

3UUF11

(X5) DATE

4/7/10  
If continuation sheet 1 of 11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/03/2010</b>
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1090 Continued From page 1

3. The shower curtain located in the main bathroom, was torn and hanging from the rings.
4. The vents throughout the facility evidenced rust.
5. The kitchen cabinets were observed to have dried food debris.
6. The hardwood floors were dirty and grimy.
7. The main bathroom smelled of urine.
8. The wall mirror in the dining room was observed unclean and dirty.
9. Residents #1, #3 and #4's dressers had missing handles.

1090

1090

3504.1

This Statute will be met as evidenced by:

1. The chandelier has been cleaned and light bulbs replaced.
2. The shower curtain located in the main bathroom was torn and hanging from the rings. The shower curtain has been replaced.
3. All kitchen cabinets have been cleaned.
4. Vents have been painted.
5. Hardwood floors appear grimy and dirty but actually needs to be resurfaced. This process will be done when the individuals are out of the home for a few days due the strong fumes created in completed this process.
6. The main bathroom has been cleaned and odor free.
7. The wall mirror has been cleaned.
8. Handles replaced on dresser drawers.

*4-6-10 ongoing*

1095 3504.6 HOUSEKEEPING

Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.

This Statute is not met as evidenced by:  
Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to store poisons and caustic agents in a locked cabinet and/or out of direct reach of each resident, for four of the four residents residing in the facility. (Residents #1, #2, #3 and #4)

The finding includes:

During the environmental walk-thru on February 23, 2010, beginning at 2:20 p.m., caustic agents (i.e., all purpose cleaner, bleach, and bathroom cleaners) were observed being stored openly

1095

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1095	Continued From page 2 underneath the residents' bathroom. The residents were observed to use the bathroom several times prior to the environmental walk-thru. Furthermore, observation of basement revealed bleach and washing powders were being stored openly. Residents were observed in the basement with direct care staff retrieving their laundry. The unsecured caustic agents were confirmed with the house manager on the same day, during the environmental walk-thru.	1095	<i>1090, continued</i>  The home manager will completed weekly environmental checks of the home and deploy staff to complete outstanding housekeeping concerns. The Home Manager will also complete weekly maintenance requests for repairs needed. Verification of completed repairs will be maintained by both the maintenance department and home manager	<i>4.6.10 ongoing</i>
1096	<b>3504.7 HOUSEKEEPING</b>  No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area.  This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that caustic agents were not stored in the food preparation and serviced area, for four of the four residents residing in the facility. (Residents #1, #2, #3 and #4)  The finding includes:  During the environmental inspection on February 23, 2010 at 2:20 p.m., caustic agents (bleach, comet, etc.) were observed stored in a food preparation area in a cabinet underneath the kitchen.	1096	  <b>1206</b>  <b>3504.7</b>  This Statute will be met as evidenced by:  The consultant has been requested to provide an updated health certificate. The nurse health certificate is on file. Reference response to W122 in regards to monthly audits of personnel records.	  <i>3.19.10 ongoing</i>
1206	<b>3509.6 PERSONNEL POLICIES</b>  Each employee, prior to employment and annually thereafter, shall provide a physician's	1206		

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1206	Continued From page 3  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 GHMRP failed to ensure each staff and consultant had a current health certificate, for one of the eleven consultants and one of the four nurses.  The finding includes:  Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on February 22, 2010, beginning at 4:55 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for one of the eleven consultant (occupational therapist), and one of the four nurses.	1206		
1227	3510.5(d) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;  This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review current training in	1227	1227 (3510.5 (d))  This Statute will be met as evidenced by:  One staff completed the CPR/First aid training in December 2009 (sign-in sheet) and currently is awaiting receipt of the card. The other staff CPR/first aid was completed 9.17.09. This information has been filed in the employee records for review. HR will continue to monitor and track to ensure documents are filed in a timely manner. Also, reference response to W122, in reference to monitoring compliance.	3.4.10 <i>ongoing</i>

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I 227	Continued From page 4  cardiopulmonary resuscitation (CPR), for two of the ten staff and current training in first aid, for three of the ten staff.  The finding includes:  Review of the personnel and training records on February 22, 2010, beginning at 4:55 p.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for two of the ten staff and current training in first aid, for three of the ten staff.	I 227		
I 401	<b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b>  Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.  This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that residents received comprehensive functional assessments, for one of the two residents in the sample. (Resident #1)  The finding includes:  Observation of the morning medication administration on February 22, 2010, at 8:05 a.m., revealed Resident #1 received Fluphenazine Hydrochloride. Interview with the licensed practical nurse (LPN) on February 22, 2010, during the medication administration, indicated that the medication was prescribed for	I 401	<b>1401 (3520.3)</b>  This statute will be met as evidenced by:  Reference response to W212.	<b>4.7.10</b> <i>ongary</i>

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I 401	Continued From page 5 behavior management.  Review of the Resident #2's physicians orders dated February 2010, on February 22, 2010, at 10:30 a.m., revealed that the aforementioned medications were incorporated in a Behavior Support Plan (BSP) dated June 22, 2009. Continued review of the orders revealed that the aforementioned medication was used to treat his diagnosis of schizophrenia. This information was verified through the review of the resident's psychological assessment dated July 2, 2009.  Client #1's medical evaluation dated July 6, 2009, on February 22, 2010, at approximately 10:50 a.m., the evaluation consumed that the the psychotropic medications were prescribed to address behaviors associated with a diagnosis of schizophrenia.  Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.	I 401		
I 406	<b>3520.8 PROFESSION SERVICES: GENERAL PROVISIONS</b>  Each professional service provided shall be documented in each resident ' s record.  This Statute is not met as evidenced by: Based on staff interview and record review, the the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the registered nurse (RN) performed quarterly nursing assessments were documented in each resident record, for one of the two residents, included in the sample. (Resident #1)  The finding includes:	I 406	1406  3520.8  Quarterly assessment have been completed for #1. Reference response to W336.	4.1.10 ongoing

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I 406	Continued From page 6	I 406		
I 424	<p>3521.5(a) HABILITATION AND TRAINING</p> <p>Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client:</p> <p>(a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan;</p> <p>This Statute is not met as evidenced by: Based on staff interviews and record review, the facility's Group Home for Mentally Retarded Persons (GHMRP) qualified mental retardation professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident has successfully completed an objective identified in the IPP, for two of the two residents included in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. The QMRP failed to revise Resident #1's IPP once he met the established criteria.</p> <p>Review of Resident #1's IPP dated July 6, 2009, on February 23, 2010, at approximately 2:10 p.m., revealed the following program objectives:</p>	I 424	<p>1424 (3521.5) (a)</p> <p>This Statute will be met as evidenced by</p> <p>1. Reference response to W255</p>	<p>4.7.10 ongoing</p>

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I 424	Continued From page 7  - "With verbal prompting, [the resident] will complete the steps of making his bed on 100% of the trials for the month, for six consecutive months as measured by active treatment documentation."  Record verification of the data sheets, revealed that the client met the established criteria since June 2009.  - "With verbal prompting, [the resident] will complete the steps of vacuuming the carpet in the basement area on 80% of the trials recorded for the month for six consecutive months as measured by active treatment documentation."  Record verification of the data sheets, revealed that the resident met the established criteria since November 2009.  Interview conducted with QMRP at the same time, verified that the aforementioned programs had not been revised once he met the established criteria.  b. Review of Resident #2's IPP dated June 30, 2009, on February 23, 2010, at approximately 10:00 a.m., revealed the following program objectives:  Review of Resident #2's IPP dated June 30, 2009, revealed a program objective which stated, "Given verbal prompts, [the client] will brush his teeth and gums with a battery operated tooth brush 80% of the trials". Review of the QMRP monthly notes dated from August 2009 through January 2010, revealed the resident was independent or required verbal prompts since September 2009.	I 424		

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I 424	Continued From page 8  There was no evidence that the QMRP revised the program (tooth brushing).	I 424		
I 436	3521.7(f) HABILITATION AND TRAINING  The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:  (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);  This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Residents #1 and #3)  The finding includes:  1. Observation during the morning medication observation, on February 22, 2010, at 8:25 a.m., the licensed practical nurse (LPN) was administering Resident #1 his medications by punching the medications from the bubble pack, providing hand over hand assistance to Resident #1 with pouring a cup of water and handing the medication cup to the resident. The client consumed the pills and drank the water with verbal prompts.  Interview with the LPN, after the medication pass, revealed the client did not participate in a self-medication training program. Review of the	I 436		

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I 436	Continued From page 9  record revealed no self medication assessment. However, Resident #1 was observed pouring liquid into cups, during his meals, independently, and reading the newspaper.  Review of Resident #1's Individual Program Plan (IPP) dated July 6, 2009, on February 23, 2010, at approximately 11:00 a.m., revealed no program goal or objective for the resident to receive training in self-medication skills development.  2. On February 22, 2010, at 8:05 a.m., Resident #2 was observed during his medication administration. The LPN was observed punching all the client's medication from the bubble packs, pouring a cup of water and giving them to the client. The resident consumed his medications with many verbal prompts.  Interview with the LPN, after the medication pass, revealed the resident did not participate in a self-medication program. Review of the record revealed no self medication assessment. Review of Resident #2's Individual Program Plan (IPP) dated July 30 2009, on February 22, 2010, at approximately 2:00 p.m., revealed no program goal or objective for the resident to receive training in self-medication skills development.	I 436	1436 (3521.7 (f))  This Statute will be met as evidenced by:  Reference response to W371 for #1 and #3.	4.6.10 ongoing
I 484	3522.11 MEDICATIONS  Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.  This Statute is not met as evidenced by: Based on observation and record review, the Group Home for Mentally Retarded Persons	I 484	1484 (3522.11)  3522.11  Reference responses to W381.	3.26.10 ongoing

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I 484	Continued From page 10  (GHMRP) nurse failed to remove from use, out dated medications, for one of four residents residing in the facility. (Resident #3)  The findings include:  On February 23, 2010, beginning at 2:20 p.m., during an environmental inspection, a jar of hydrocortin cream was observed on Resident #3's dresser. The label on the jar had an expiration date of May 9, 2009. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired.  At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medications were removed from the residents' supplies after the expiration date.	I 484		

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R 000	INITIAL COMMENTS  A licensure survey was conducted from February 22, 2010, through February 23, 2010. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a population of four male residents with various levels of mental retardation and disabilities.  The findings of the survey was based on observations at the group home and one day program, interviews with the residents and staff, and the review of clinical and administrative records including incident reports.	R 000		
R 171	4703 2 EMPLOYED ON THE EFFECTIVE DATE  A facility shall not continue to employ or use the contract services of a person whose criminal history is found to be in noncompliance with section 4705.  This Statute is not met as evidenced by: Based on record review and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure individuals whose criminal history is found to be in noncompliance with section 4705, be employed for one of ten staff. (Staff #3)  The finding includes:  Review of the personnel records on February 22, 2010, beginning at 4:55 p.m., revealed Staff #3 record included a criminal background that documented the staff was a sex offender, who failed to register on February 23, 2006. Interview with the Program Director (PD) on February 22, 2010, at 5:30 p.m., indicated that the staff person was still on the current schedule. The PD called the Human Resources (HR) office and was	R 171	<b>R243 4703.2</b>  This statute will be met as evidenced by:  Reference response to W122:	<b>3.4.10</b> <b>DMG/14</b>

Health Regulation Administration

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

TITLE  
*D.R.S.*

(X8) DATE  
**4.7.10**

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/03/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL DEVELOPMENT, INC.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 WALNUT STREET, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 171	Continued From page 1  informed that the staff person told HR that , "That was not me." when questioned about the criminal background check disposition. On February 23, 2010 at approximately 11:00 a.m., the PD gave the surveyor notification that the staff had been removed from the schedule on February 23, 2010  Review of the facility personnel policy on February 23, 2010, at approximately 3:00 p.m., revealed that a policy clearance must be obtained prior to employment. the police clearance should include employment and where the person lived, within the past seven years. The HR department failed to verify the police clearance.	R 171		
R 243	4705.1(y) CRIMINAL OFFENSES  Except as provided in subsection 4705.2, a facility shall not employ or use the contract services of an unlicensed person who has been convicted, within the seven (7) years prior to a criminal background check conducted pursuant to these rules, of one or more of the following offenses or the equivalent thereof:  (y) Sexual abuse;  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to implement policies and procedures to ensure the health and safety of four of four clients residing in the facility. (Client #1, #2, #3, and #4)  The finding includes:  Cross Ref. W152. The facility failed to ensure obtain a complete and accurate criminal background check for Staff #3 prior to employment as evidenced below:	R 243	R243/4705.1 Criminal Offenses  This Statute will be met as evidenced by:  Reference response to W122.	3.12.10 organa

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0201</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/03/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL DEVELOPMENT, INC.</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 WALNUT STREET, NE WASHINGTON, DC 20018</b>
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R 243	<p>Continued From page 2</p> <p>Review of staff personnel records on February 22, 2010, beginning at 4:55 p.m., revealed one of the ten staff providing direct services to the clients, had a criminal background check that included a "sex offender (Staff #3)." Further review of the background check revealed that Staff #3 had failed to register on February 23, 2006. Interview with the Program Director (PD) on February 22, 2010, at 5:30 p.m., indicated that the staff person was still on the current schedule. The PD called the Human Resources (HR) office on February 22, 2010, at approximately 5:30 p.m., and was informed that the staff person told them, "That is not me." On February 23, 2010, at approximately 11:00 a.m. the PD gave the surveyor notification that the staff had been removed from the schedule, immediately.</p> <p>Review of the facility's policy on February 23, 2010, at approximately 3:00 p.m., revealed that a police clearance must be obtained prior to employment. The police clearance should include employment and where the person lived, within the past seven years.</p>	R 243		
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