

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

PRINTED: 06/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2012
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from May 16, 2012 through May 18, 2012. A sample of three clients was selected from a population of six women with profound intellectual disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, administrative staff and one client's niece, as well as a review of client and administrative records, including incident reports.

The Individual Development, Inc. facility is in compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities.

Received 6/21/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tiffany D. Samuels Director of Residential Services</i>	TITLE	(X8) DATE <i>6/15/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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I 000	INITIAL COMMENTS A licensure survey was conducted from May 16, 2012 through May 18, 2012. A sample of three residents was selected from a population of six women with profound intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, administrative staff and one resident's niece, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000	
I 227	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 staff interview and record review, the group home for persons with intellectual disabilities (GHIPD) failed to ensure one of seven licensed practical nurses (LPNs) working in the facility had current training to implement cardiopulmonary resuscitation (CPR). (LPN #7). The finding includes: During the entrance conference on May 16, 2011, at 3:45 p.m., the qualified intellectual disabilities	I 227	I 227 This statute will be met as evidenced by: LPN#7 has been removed from the schedule until she provides evidence of CPR training. IDI has begun implementing an electronic database that tracks CPR expiration dates for employees and alerts the HR and training director before they expire. IDI's Training Director informs employees in advance that their training is expiring. IDI's Training Director will coordinate with HR to ensure removal off the schedule for employees who are not in training compliance. 6/30/12

Health Regulation & Licensing Administration

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

[Signature] Director of Residential Services

6/15/12 (X6) DATE

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I 227	Continued From page 1 professional (QIDP) was requested to obtain the training records for the surveyor's review. Record review on May 17, 2012, 2011, beginning at 11:10 a.m., revealed the personal file and training record were not presented for LPN #7. Interview with the QIDP on May 17, 2012, at 2:25 p.m., revealed the the personnel file would be obtained for the surveyor's review. Further review of the records on May 18, 2012, at 4:02 p.m., however, revealed the GHPID failed to provide evidence that LPN #7 had a current current certification in CPR.	I 227		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure resident records were current and maintained for accuracy, for one of three residents in the sample. (Resident #2) The findings include: 1. The GHPID's nursing services failed to seek clarification from Resident #2's primary care physician timely, as follows: On May 16, 2012, beginning at 6:35 p.m., Resident #2's enteral feeding was observed. Before administering the resident's medication, the licensed practical nurse LPN1 checked the	I 260	I260 Statute will be met as evidenced by: 1. The LPN has clarified the order with the Physician for Resident # 2. The QDDP will follow-up with nutritionist to ensure that the nutritional assessment is updated to reflect the revisions to Resident #2 Physician Order. IDI's NP will train the LPN and RN on IDI's Physician's Order Policy. The LPN and RN will review the Physician Orders monthly for accuracy and report any discrepancies to the Primary Care Physician.	6/13/12

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I 260	<p>Continued From page 2</p> <p>resident's G-tube placement and residual. She then administered one can (8.45oz) of Replete with Fiber, after observing there was no residual. At 6:43 p.m., the LPN flushed the resident's G-tube with 150cc of water after having finished administering the nourishment.</p> <p>Similarly, on May 17, 2012, an LPN was observed administering Resident #2's nourishment at her day program, beginning at 12:01 p.m. After she checked the resident's G-tube placement and residual, she administered one can of Replete with Fiber, followed by 150cc of water.</p> <p>On May 17, 2012, at 5:55 p.m., review of Resident #2's physician order sheets (POS) dated March 1, 2012 ("valid for 120 days") revealed the following order: "CHECK RESIDUAL AND FLUSH G-TUBE WITH 25ML OF WATER, AND PRIOR TO FEEDING - HOLD IF RESIDUAL IS >50ML RECHECK IN 1HR, IF RESIDUAL IS STILL >50ML CALL MD FOR FURTHER INSTRUCTION."</p> <p>On May 17, 2012, at 5:57 p.m., when the facility's LPN Coordinator was asked if this order meant the resident's G-tube should be flushed with 25ml prior to feeding, she replied "yes." She was then informed that observations in the home and at day program showed that LPNs were not administering the 25ml flush prior to feeding. Examination (jointly) of the resident's medication administration records (MARs) for the months of February 2012 - May 2012 (residential and day program) revealed no documentation showing that nurses flushed her G-tube with 25ml of water prior to feeding. The LPN Coordinator noted how the order was written (i.e. a comma followed by the word "and") stated that this was not clearly written and she would seek clarification from the</p>	I 260	

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I 260	<p>Continued From page 3 primary care physician (PCP).</p> <p>On May 18, 2012, at 9:30 a.m., the LPN Coordinator stated that she had spoken with the PCP who informed her that he wanted Resident #2's G-tube flushed with 25ml flush of water prior to feeding. She was writing a telephone order accordingly. When asked, she indicated that she was unsure whether this had always been the PCP's expectation or if this was a new order. She then acknowledged that the facility's nursing team had not identified the issue prior to this survey.</p> <p>It should be noted that review of Resident #2's nutrition records on May 18, 2012, beginning at 3:15 p.m., revealed that the nutritionist documented having examined the resident's fluid intake. The nutritionist had prepared an Annual Assessment on August 1, 2011 and then subsequent quarterly assessments on November 3, 2011, January 24, 2012 and April 11, 2012. Although there was no evidence that the nutritionist was aware of an order to flush the G-tube with 25ml of water prior to each feeding, there also was no indication that she had any concerns regarding the resident's overall fluid intake or hydration status.</p> <p>2. The GHPID failed to ensure that staff documented a daily assessment of residents' adaptive equipment, in accordance with the facility's policies, as follows:</p> <p>On May 16, 2012, at 6:00 p.m., Resident #3's wheelchair was observed to have no anti-tippers attached in the back. When asked at 6:20 p.m. the LPN Coordinator stated that she was previously unaware of the anti-tipper observed on the floor and she was unsure whether it belonged</p>	I 260	<p>2. The anti-tippers on Resident's # 2 wheelchair have been replaced. The QDDP, RD, and DSP's for the home will be retrained on IDI's Adaptive Equipment Protocol. The RD will review the adaptive equipment documentation weekly to ensure DSP's are implementing the established protocol and procedures for monitoring adaptive equipment.</p> <p style="text-align: right;">6/20/12</p>

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I 260	Continued From page 4 to Resident #3. On May 17, 2012, beginning at 2:34 p.m., interview with the facility's qualified intellectual disabilities professional (QIDP), the residential director (RD) and a past-QIDP for this facility revealed that prior to the surveyor asking about Resident #3's anti-tippers on the evening before, they were unaware of any repairs needed on the resident's wheelchair. The past-QIDP stated that staff were expected to examine each resident's adaptive equipment daily and report any problems or concerns identified. The RD and past-QIDP stated that yes, staff were expected to document a daily inspection of each resident's adaptive equipment. On May 17, 2012, at 2:45 p.m., the RD and past-QIDP reported having gone through Resident #3's program book and other records and were unable to find documented evidence of staff inspections of the wheelchair. They then acknowledged that without said documentation, the resident's record could not be used to verify when the need to repair or replace Resident #3's anti-tippers was first identified. On May 18, 2012, at 1:34 p.m., the past-QIDP stated that all of the facility's staff were present that day for a mandatory staff meeting and that she had just provided them training regarding the facility's adaptive equipment policies and procedures. She then acknowledged that staff had not been documenting the nightly review of adaptive equipment.	I 260		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and	I 261		

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I 261	Continued From page 5 made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disability (GHPID) failed to ensure that each record was kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies for three of three of three residents in the sample. (Residents #1, #2 and #3) The finding include: 1. During the entrance conference on May 16, 2011, at 4:15 p.m., the qualified intellectual disabilities professional (QIDP) revealed that the residents' finances were managed by the facility. The QIDP was requested to provide the residents' financial records for the current survey period for review. On May 18, 2012, at 4:29 p.m., the QIDP provided bank statements and the records of income and expenditures for Residents #1, #2, and #3 only for the period of October 1, 2011 through March 31, 2012. The QIDP indicated, however, that the financial records for April 2011 through September 2011 were not available at the facility. No additional information was presented before the survey ended that evening. [Note: The GHPID was provided the opportunity to forward the remaining financial records for Residents #1, #2, and #3 post survey. No additional information, however, was submitted.] 2. Interview with the QIDP on May 16, 2012, at 4:15 p.m., revealed that Resident #1 received	I 261	I261 Statute will be met as evidenced by: 1. The home copy of the Individuals financial record has been reconciled. The financial record should be reconciled monthly by the RD for the home and IDI's accounting department. The QDDP and RD will be trained on Client Finances, Record Keeping, and Survey Procedures. The QDDP will audit the financial records monthly in order to ensure compliance with IDI's established policy.	6/30/12

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I 261	<p>Continued From page 6</p> <p>Ativan as sedation prior to appointments due to anxiety. Further discussion with the QIDP revealed that the use of all sedation was reviewed and approved by the facility's human rights committee (HRC) prior to administration. At 3:50 p.m., the QIDP was asked to provide the minutes of the HRC during which the use of sedation was approved for the resident.</p> <p>On May 17, 2012, at 3:10 p.m., record review revealed Resident #1 was prescribed sedation on the following dates:</p> <p>a. Ativan 2 mg on May 5, 2012 for a podiatry appointment on March 8, 2012 b. Ativan 2 mg on December 16, 2011 prior to CT scan on December 20, 2011.</p> <p>On May 18, 2012, at 3:52 p.m., review of the minutes provided during the survey revealed they were dated for the period prior to April 27, 2011. The facility failed to make available for review the HRC minutes by which the survey team could verify compliance with this regulation.</p>	I 261	<p>2. HRC approval was provided for sedation for Resident #1's podiatry appt. for 4/17/12. The appointment was not completed with sedation until 5/8/12. According to HRC notes, telephone approval was requested for Resident #1's emergency cat scan on 12/19/11 documentation of this request was not reflected on the "Human Rights Committee Form" IDI DRS will ensure documentation of emergency approvals are provided for the HRC record and reviewed by the HRC committee meeting in a timely fashion. QDDP will be retrained on Survey Procedures to ensure all records for the Individuals are available at the time of the survey. IDI's DRS will train all IDI QDDP's on Emergency Sedation Procedures.</p> <p style="text-align: right;"><i>6/30/12</i></p>
I 292	<p>3514.3 RESIDENT RECORDS</p> <p>Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.).</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to maintain resident records in accordance with requirements of D.C. Law 2-137 (now Title 7, Chapter 13), for the one resident in the sample. (Resident #1)</p> <p>The findings include:</p>	I 292	

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I 292	Continued From page 7 Title 7, Chapter 13; D.C. Code 7-1305.12 (formerly 6-1972) Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (9) "A summary of each significant contact by a professional person with a customer" The GHPID failed to obtain complete reports showing the results of tests performed for Resident #2 by an outside laboratory, as follows: 1. On May 18, 2012, at 11:10 a.m., a culture and sensitivity (C/S) report dated January 20, 2012, was observed in Resident #2's record. There was no corresponding urinalysis (U/A) report stapled to it, or found elsewhere in the resident's record. When brought to the attention of the LPN coordinator, at 12:15 p.m., she acknowledged the U/A was not in the record. [Note: At 1:30 p.m., she presented a U/A report dated January 20, 2012, saying that the laboratory had just sent the report to the facility via facsimile moments earlier.] 2. On May 18, 2012, at 11:22 a.m., review of Resident #2's urinalysis report for a specimen collected on April 12, 2012 revealed that a C/S report with Resident #1's name on it (specimen collected April 10, 2012) had been stapled to it and filed in Resident #2's record. When brought to the attention of the LPN coordinator, at 11:24 a.m., she removed the other resident's C/S report from Resident #2's record. She could not locate a C/S report that corresponded with the resident's	I 292	I292 1, 2 Statute will be met as evidenced by: All lab results for the Individuals in the home have been obtained, they are current and available for review. The expectation is that lab results are obtained in 24 hrs whenever possible. The RN for the home will train the LPN on IDI's policy on "Laboratory Analysis." The LPN for the home will discuss any barriers to obtaining lab results with the supervising RN all attempts to obtain lab results will be reflected on nursing notes and documented during monthly Ground Rounds.	05/30/12

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I 292	Continued From page 8 April 12, 2012 U/A in the record. [Note: At 1:30 p.m., she presented a C/S report dated April 12, 2012 for Resident #2, saying that the laboratory had just sent the report to the facility via facsimile moments earlier.]	I 292		