

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20018
--	--

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

W 000 INITIAL COMMENTS

A recertification survey was conducted from 2/7/12 through 2/9/12. A sample of three clients was selected from a population of five women and one man 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 three day programs, interviews with direct support staff, administrative staff and one client's father, as well as a review of client and administrative records, including incident reports.

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, interview and record review, the facility failed to ensure that outside services met individuals' needs, for one of three sampled clients with maladaptive behaviors. (Client #1)

The finding includes:

1. The day program failed to ensure staff implemented Client #1's behavior support plan (BSP).

W 000

Received 3/8/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 120

W120 This Standard will be met as evidenced by:

1. Review of record show that Individual #1 behavior support plan is jointly written to manage her behavior both at the Group Home site and at the day program site. QDDP and the psychologist will conduct an in-service training at Client #1's Day Program on her Behavior Support implementation and documentation.
2. QDDP and the psychologist will conduct an in-service training at Client #1's Day Program on her Behavior Support implementation and documentation.

3/16/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tiffany D. Samuels Director of Residential Services</i>	TITLE	(X6) DATE <i>3/14/12</i>
---	-------	-----------------------------

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.

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER

INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

431 53RD STREET, SE
WASHINGTON, DC 20018

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

W 120 Continued From page 1

On 2/8/12, at 11:58 a.m., observations conducted at the day program revealed Client #1 was observed to stomp her left foot four (4) times on her wheelchair footrest very hard. A few seconds later, the client attempted to kick the surveyor. At 12:00 p.m., Staff #1 (assigned by group home as a 1:1) was observed to transport the client to the classroom. The client was observed to kick the bottom of the table 6 times very hard while having a tantrum. Shortly afterwards, day program nurse #1 attempted to administer Client #1 her noon medications. The medication pass was unsuccessful because Client #1 attempted to kick day program nurse #1 each time she tried to administer the medications. At 12:04 p.m., Client #1 was then observed to hit herself approximately 4 times in the face without interventions from Staff #1 or day program staff #1 (DPS #1) who were both responsible for the client. At no time did staff intervene during the observed behaviors.

Interviews with Staff #1 and DPS #1 on 2/8/12, at approximately 12:15 p.m., revealed that Client #1 had a BSP for her safety and to manage her maladaptive behaviors (i.e. physical aggression (kicking) and self-injurious behaviors (SIB)). Further interview with DPS #1 revealed that when Client #1 exhibited SIB, staff was to move her hands away from her face. When asked, Staff #1 and DPS #1 both indicated that kicking and SIB were two of Client #1's targeted behaviors.

On 2/9/12, at 12:00 p.m., review of Client #1's BSP dated 6/9/11, revealed tantrums, kicking and SIB were three of her targeted maladaptive behaviors. Continued review of the BSP revealed that when the client is engaged in SIB behaviors, staff should verbally direct Client #1 to calm down.

W 120

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 120	<p>Continued From page 2</p> <p>while simultaneously moving her hand away from her face. When Client #1 is engaged in kicking, the BSP indicated that staff should say "stop kicking". If she continues to be stimulated, staff should use nonexclusionary time out by verbally directing Client #1 to go to the behavior treatment room to calm down.</p> <p>2. The day program failed to ensure staff document Client #1's behaviors on the data collection sheets in accordance with the BSP.</p> <p>Review of the corresponding documentation record for Client #1's previously mentioned exhibited behaviors were reviewed on 2/9/12. The documentation revealed that the day program staff failed to document the observed behaviors that occurred on 2/8/12.</p> <p>According to Client #1's BSP reviewed on 2/9/12, at 12:00 p.m., "staff must document all SIB and aggressive behaviors of any kind. Any non-aggressive or non-self injurious behaviors involving accidentally bumping into hard surfaces whether or not a bruise is immediately apparent must also be documented. Staff must document all SIB and aggressive behaviors of any kind because they usually lead to the subsequent observations of bruises." The frequency of physical aggression will be recorded as it occurs and tallied monthly.</p> <p>On 2/9/12, at approximately 11:00 p.m., an interview was conducted with Staff #1 and DSP #1 to ascertain information regarding the failure to document Client #1's behaviors. They both indicated that they did not record the Client #1's behaviors on the data collection sheets that</p>	W 120		

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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 120 Continued From page 3
occurred on 2/8/12. This was confirmed through the review of the day program's data collections sheets on 2/9/12, at approximately 4:10 p.m.

Note: It should be noted that Client #1's behaviors usually resulted in bruising due to an Axis III diagnosis of thrombocytopenia. Client #1 also had the diagnoses of Osteopenia and Easy Bruisability.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the facility's qualified Intellectual disabilities professional (QIDP) failed to ensure the coordination, monitoring, and implementation of each clients' habilitation and planning, for one of the three sampled clients. (Client #1)

The findings include:

The QIDP failed to monitor and integrate services to ensure Client #1 was effectively assisted with managing her behaviors, as evidenced below:

On 2/8/12, at 8:46 p.m., observations during the morning medication administration pass revealed Client #1 attempted to kick the nurse approximately three (3) times, but was unsuccessful. Moments later, the client was successful in kicking the nurse one time. The nurse replied "stop kicking me." There were no

W 120

W 159

W159
This Standard will be met as evidenced by

3/16/12

The QDDP will ensure consistent documentation at the day program by providing the 1:1 support staff ABC data sheet to accompany individual #1 to the day program site on daily basis to ensure accurate documentation of behavior incidents as occur. The QDDP will conduct routine day program visits/monitoring to ensure compliance with the training as provided

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 159	<p>Continued From page 4</p> <p>further interventions observed. At 11:58 p.m., observations at Client #1's day program revealed the client exhibited aggressive behaviors of hitting herself and kicking others. Specifically, Client #1 was observed to kick the day program medication nurse during the medication administration pass. Neither the day program nurse nor staff was observed to intervene during the behaviors. Continued observations that evening at 5:03 p.m., revealed the client was observed to kick the dining table several times while eating dinner. A few seconds later, the client was observed to hit herself two times in the face. Again, there was no intervention by staff.</p> <p>Interviews with Staff #1 and day program staff #1 (DPS #1) on 2/8/12, at approximately 12:15 p.m., revealed that Client #1 had a behavior support plan (BSP) for her safety and to address her maladaptive behaviors (i.e. physical aggression (kicking) and self-injurious behaviors (SIB)). Further discussion with Staff #1 revealed that when Client #1 presented with self-injurious behavior (SIB), staff should ask her to calm down and move her hands away from her face. Staff #1 indicated that staff should verbally prompt Client #1 to stop kicking when the behavior is observed and escort her to another location.</p> <p>On 2/9/12, at 12:00 p.m., review of Client #1's BSP dated 6/9/11, verified that when the client exhibited SIB, staff should verbally direct <client's name> to calm down while simultaneously moving her hand away from her face. The BSP also indicated that staff should verbally prompt Client #1 to stop kicking when the behavior is observed and escort her to another location. Additional review of the BSP revealed</p>	W 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 159	<p>Continued From page 5</p> <p>that staff should document the frequency of aggression as it occurs.</p> <p>Review of the corresponding BSP data collection record on 2/9/12, at approximately 2:00 p.m., revealed that there was no documentation collected for any of the observed behaviors on 2/8/12. The facility's registered nurse (RN) was interviewed on 2/9/12, at approximately 2:20 p.m., regarding the data collection for Client #1's behavioral episode on 2/8/12. The RN stated that although she intervened during Client #1's behavior, she admittedly did not document the behavior. Further discussion with the RN revealed she had not been formally trained on Client #1's BSP.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 2/9/12, at approximately 3:30 p.m., confirmed that the residential nursing personnel had not been trained on Client #1's BSP. Review of the In-service training records on 2/9/12, at approximately 3:45 p.m., revealed no evidence that the aforementioned training for nurses had been conducted.</p> <p>Further discussion was held with the QIDP on 2/9/12, at approximately 3:55 p.m., and it was revealed to the QIDP that similar behaviors were observed exhibited by Client #1 at her day program (2/8/12). It was explained that there was no observed intervention by the day program nurse, Staff #1 or the RN during the behaviors and there was no documentation collected.</p> <p>At the time of the survey, the QIDP failed to monitor and integrate services to ensure staff and nurses were effectively trained to implement</p>	W 159	

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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 159 Continued From page 6
Client #1's BSP inclusive of necessary documentation.

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure nursing staff were provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for one of three clients with maladaptive behaviors. (Client #1)

The finding includes:

On 2/8/12, at 8:46 a.m., observations during the morning medication administration pass revealed Client #1 attempted to kick the nurse approximately three (3) times, but was unsuccessful. Moments later, the client was successful in kicking the nurse one time. The nurse replied "stop kicking me." There were no further interventions observed.

On 2/8/12, at approximately 4:45 p.m., interview with the registered nurse (RN) revealed that she had not been formally trained on how to implement Client #1 behavior support plan (BSP). Interview with the morning and evening licensed practical nurses (LPNs #1 and #2) on 2/9/12, at approximately 3:35 p.m., revealed they both had not received formal training on Client #1's BSP.

W189 3/10/12

This Standard will be met as evidenced by:
The QDDP will coordinate with psychologist to provide additional training to all staff that include medical staff providing support for individual #1.

QDDP will receive additional in-service training on program coordination and following up with programs as formulated by the IDT. QDDP will receive a refresher training on individual #1 behavior support plan implementation/documentation. QDDP will ensure that all program services recommended for individuals are implemented as outlined by the professionals. QDDP will provide a routine monitoring of individual active treatment to ensure compliance with this standard as set forth.

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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 189 Continued From page 7

W 189

Review of the In service training records on 2/9/12, at approximately 3:45 p.m., revealed that all staff direct support staff had received training Client #1's BSP. However, at the time of the survey, there was no evidence that the facility's nursing team was provided training regarding the client's BSP.

At the time of the survey, there was no evidence that the facility's nursing staff had received training on how to manage Client #1's maladaptive behaviors.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

W 249

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, the facility failed to ensure staff implemented client's behavior support plan (BSP), for one of the three sampled clients with maladaptive behaviors. (Client #1)

The finding includes:

On 2/8/12, at approximately at 5:03 p.m., Client #1 was observed to kick the dining table several times while eating dinner. A few seconds later,

W249
This Standard will be met as evidenced by:

3/16/12

Staff in the home will receive training on Client #1's BSP. Staff will receive additional training for all other Client's with BSP's in the home. The QDDP will be expected to periodically observe staff implementation of the Client's BSP's and review the documentation and make on shift corrections and provide feedback to staff on the implementation. The QDDP will schedule refresher training with staff if there are concerns noted in her observations.

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER

INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

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 249 Continued From page 8

the client was observed to hit herself two times in the face without interventions from Staff #1 who was assigned to assist her. It should be noted that Staff #1 sat directly across from the client the entire time during dinner.

Interview with Staff #1 on 2/9/12, at approximately 8:50 a.m., revealed Client #1 had a BSP for her safety and to manage her maladaptive behaviors [i.e. physical aggression (kicking) and self-injurious behaviors (SIB)]. Further interview revealed that when Client #1 presented with SIB, staff should ask her to calm down and move her hands away from her face. Staff #1 indicated that staff should verbally prompt Client #1 to stop kicking when the behavior is observed and escort her to another location. When asked, Staff #1 stated that she did not document the behaviors that occurred during the dinner meal on 2/9/12. Staff #1 further acknowledged that she did not implement the BSP when Client #1 was observed to hit herself during dinner.

On 2/9/12, at 12:00 p.m., review of Client #1's BS,P dated 6/9/11, revealed that the client's targeted behaviors included physical aggression (kicking) and self-injurious behavior (face slapping). Further review revealed that when the client exhibited SIB, staff should verbally direct her to calm down while simultaneously moving her hand away from her face. Continued review of the BSP revealed that "staff should verbally direct <client's name> to calm down while simultaneously moving her hand away from her face.

At the time of the survey, there was no evidence that staff implemented Client #1's BSP as

W 249

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER

INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

431 53RD STREET, SE
WASHINGTON, DC 20019

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

W 249 Continued From page 9
recommended.

W 249

W 252 483.440(e)(1) PROGRAM DOCUMENTATION

W 252

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, facility staff failed to document incidents of maladaptive behaviors in accordance with clients' behavior support plans (BSPs), for one of the three clients sampled with maladaptive behaviors. (Client #1)

The findings include:

On 2/8/12, at 8:46 a.m., Client #1 was observed to kick the facility's registered nurse (RN) during the morning medication administration pass. At 11:58 a.m., observations conducted at the day program revealed Client #1 was observed to exhibit maladaptive behaviors of physical aggression (kicking) and self-injurious behaviors. At 5:03 p.m., Client #1 was observed to kick the dining room table very hard and she hit herself twice in the face during dinner.

On 2/8/12, at approximately 4:45 p.m., interview with the RN revealed that she did not document the client's behavior of kicking on the data collection sheets. On 2/9/12, at approximately at 8:50 a.m., interview with Staff #1 revealed that she did not document the behaviors that occurred on 2/8/12 during dinner.

W252

This Standard will be met as evidenced by:

Staff in the home will receive training on Client #1's BSP. Staff will receive additional training for all other Client's with BSP's in the home. The QDDP will be expected to periodically observe staff implementation of the Client's BSP's and review the documentation and make on shift corrections and provide feedback to staff on the implementation. The QDDP will schedule refresher training with staff if there are concerns noted in her observations

3/10/12

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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 252 Continued From page 10

W 252

Review of Client #1's BSP dated 6/9/11, on 2/9/12, at 12:00 p.m., revealed that the client's targeted behaviors included physical aggression (kicking). Further review of the BSP revealed that staff must document all SIB and aggressive behaviors of any kind. The frequency of physical aggression will be recorded as it occurs and tallied monthly.

On 2/9/12, at approximately 2:00 p.m., review of the day program's and the facility's behavior data collection sheets for 2/8/12, revealed they both failed to document the behaviors of kicking and SIB observed on 2/8/12.

W 368 483.460(k)(1) DRUG ADMINISTRATION

W 368

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 without error, for one of the six clients residing in the facility. (Client #2)

The finding includes:

On 2/9/12, at 8:09 a.m., the facility's registered nurse (RN) crushed Client #2's medications, including a Calcium 600 mg with Vitamin D 400 units tablet, and stirred them into 20 ml water. At 8:16 a.m., the RN administered the crushed calcium and other medications via G-tube. At 8:57 a.m., the RN returned to Client #2's bedroom to provide her G-tube feeding.

W368

This Standard will be met as evidenced by:

2/10/12

Review of record showed that cline #2 medication time has been changed to indicate medication to be administered with food: RN supervisor/LPN will receive additional training on medication administration protocols/policies and procedures.

NP will randomly check and monitor client record and medication administration to ensure ongoing compliance with this standard.

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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 368 Continued From page 11
explaining that the client was to receive nothing by mouth. At 9:01 a.m., the RN began pouring one can of Jevity 1.2 into the client's G-tube, which was 45 minutes after the medication administration.

On 2/8/12, at approximately 10:20 a.m., review of Client #2's physician's order sheets (POS) dated December 2011 ("valid for 120 days"), revealed the physician ordered "Calcium with Vitamin D 600 mg - 400 tablet, 1 tab via G-tube twice daily for osteoporosis. Take with food/meal."

When interviewed on 2/8/12, at 10:28 a.m., the RN reviewed the written order and confirmed the medication was to be administered "with food/meal" as written. written order and stated that she would ask the pharmacy about the physician's order. At 10:44 a.m., the RN stated that the pharmacist had informed her that the calcium with vitamin D tablet "can cause stomach upset" if taken without food. The RN further stated that she would discuss with the nurse practitioner a change in administration time, to ensure the crushed medications (including the calcium with vitamin D), were administered in accordance with the physician's orders.

W 368

W 440 483.470(l)(1) EVACUATION DRILLS

The facility must hold evacuation drills at least quarterly for each shift of personnel.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)

W 440

W440 *3/14/12*
This Standard will be met as evidenced by:
Residential Director and DSP will receive in-service training on procedures regarding fire drill. The residential Director will conduct monthly check of fire drill record to ensure ongoing compliance with this standard.

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

PRINTED: 02/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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 440 Continued From page 12

W 440

The finding includes:

The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:

On 2/8/12, at 2:30 p.m., interview with the facility's qualified intellectual disabilities professional (QIDP) revealed that there were three designated shifts (6:00 a.m. - 2:30 p.m.; 2:00 p.m. - 10:30 p.m.; and, 10:00 p.m. - 6:30 a.m.), Monday through Friday. Further interview revealed that there were two designated shifts (6:00 a.m. - 6:30 p.m. and 6:00 p.m. - 6:30 a.m.) on Saturdays and Sundays.

The facility's fire drill log records for the period January 2011 - February 2012 was reviewed on 2/8/12, beginning at 2:32 p.m. There was no evidence of any drills conducted during the 6:00 a.m. - 2:30 p.m. shift on weekdays since 10/31/11 (more than 3 months earlier).

When interviewed on 2/8/12, at 2:42 p.m., the QIDP acknowledged that the most recent fire drill record for the morning shift was dated 10/31/11. She further stated that she would ask the house manager (HM) if there were any additional drill reports, dated more recently. During the Exit conference on 2/9/12, the QIDP and HM acknowledged the deficiency. The QIDP then stated that a drill was conducted during the morning shift earlier that day.

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

I 000 INITIAL COMMENTS

A licensure survey was conducted from 2/7/12 through 2/9/12. A sample of three residents was selected from a population of five women and one man with profound intellectual disabilities.

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

I 180 3508.1 ADMINISTRATIVE SUPPORT

Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

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 adequate administrative support had been provided to effectively meet the needs, for one of the three residents included in the sample. (Resident #1)

The findings include:

The QIDP failed to monitor and integrate services to ensure Resident #1 was effectively assisted with managing her behaviors, as evidenced below:

On 2/8/12, at 8:46 p.m., observations during the morning medication administration pass revealed Resident #1 attempted to kick the nurse approximately three (3) times, but was

I 180

This Statute will be met as evidenced by:
Staff in the home will receive training on Client #1's BSP. Staff will receive additional training for all other Client's with BSP's in the home. The QDDP will be expected to periodically observe staff implementation of the Client's BSP's and review the documentation and make on shift corrections and provide feedback to staff on the implementation. The QDDP will schedule refresher training with staff if there are concerns noted in her observations

3/6/12

Health Regulation & Licensing Administration <i>H. Mary A. Sealus</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Director of Residential Services	(X6) DATE 8/4/12
---	---	---------------------

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
I 180	<p>Continued From page 1</p> <p>unsuccessful. Moments later, the resident was successful in kicking the nurse one time. The nurse replied "stop kicking me." There were no further interventions observed. At 11:58 p.m., observations at Resident #1's day program revealed the resident exhibited aggressive behaviors of hitting herself and kicking others. Specifically, Resident #1 was observed to kick the day program medication nurse during the medication administration pass. Neither the day program nurse nor staff was observed to intervene during the behaviors. Continued observations that evening at 5:03 p.m., revealed the resident was observed to kick the dining table several times while eating dinner. A few seconds later, the resident was observed to hit herself two times in the face. Again, there was no intervention by staff.</p> <p>Interviews with Staff #1 and day program staff #1 (DPS #1) on 2/8/12, at approximately 12:15 p.m., revealed that Resident #1 had a behavior support plan (BSP) for her safety and to address her maladaptive behaviors [i.e. physical aggression (kicking) and self-injurious behaviors (SIB)]. Further discussion with Staff #1 revealed that when Resident #1 presented with self-injurious behavior (SIB), staff should ask her to calm down and move her hands away from her face. Staff #1 indicated that staff should verbally prompt Resident #1 to stop kicking when the behavior is observed and escort her to another location.</p> <p>On 2/9/12, at 12:00 p.m., review of Resident #1's BSP dated 6/9/11, verified that when the resident exhibited SIB, "staff should verbally direct <resident's name> to calm down while simultaneously moving her hand away from her face. The BSP also indicated that staff should verbally prompt Resident #1 to stop kicking when</p>	I 180	

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 180	<p>Continued From page 2</p> <p>the behavior is observed and escort her to another location. Additional review of the BSP revealed that staff should document the frequency of aggression as it occurs.</p> <p>Review of the corresponding BSP data collection record on 2/9/12, at approximately 2:00 p.m., revealed that there was no documentation collected for any of the observed behaviors on 2/8/12. The GHPID's registered nurse (RN) was interviewed on 2/9/12, at approximately 2:20 p.m., regarding the data collection for Resident #1's behavioral episode on 2/8/12. The RN stated that although she intervened during Resident #1's behavior, she admittedly did not document the behavior. Further discussion with the RN revealed she had not been formally trained on Resident #1's BSP.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 2/9/12, at approximately 3:30 p.m., confirmed that the residential nursing personnel had not been trained on Resident #1's BSP. Review of the In-service training records on 2/9/12, at approximately 3:45 p.m., revealed no evidence that the aforementioned training for nurses had been conducted.</p> <p>Further discussion was held with the QIDP on 2/9/12, at approximately 3:55 p.m., and it was revealed to the QIDP that similar behaviors were observed exhibited by Resident #1 at her day program (2/8/12). It was explained that there was no observed intervention by the day program nurse, Staff #1 or the RN during the behaviors and there was no documentation collected.</p> <p>At the time of the survey, the QIDP failed to monitor and integrate services to ensure staff and nurses were effectively trained to implement</p>	I 180	

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 180	Continued From page 3 Resident #1's BSP inclusive of necessary documentation.	I 180		
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure all staff were afforded a job description over the past licensure year, for fourteen (14) of the 14 employee records reviewed. The findings include: Record review and interview with the qualified intellectual disabilities professional (QIDP) and house manager (HM) on 2/9/12, beginning at 2:35 p.m., revealed there were no job descriptions filed in any of the fourteen (14) staff records reviewed. The facility failed to ensure copies of those documents were filed in the employee records and presented to the survey team at the time of inspection.	I 202	I202 This Statute will be met as evidenced by: The surveyors did not indicated to the QDDP that they were unable to locate the job descriptions file during the survey period. All job description were filed inside a separate notebook that clearly marked "job description". It was presented as part of notebooks given to the surveyors during the process.	2/9/12
I 206	3509.6 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	I 206		

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 206	Continued From page 4 duties. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure all staff maintained current health certificates for four of twenty-two personnel records reviewed. [Staff #2, #10 and Consultants #7, #8] The findings include: 1. Review of Staff #2's personnel record on 2/9/12 at 3:10 p.m. revealed their health certificate was dated 12/22/10. 2. Review of Staff #10's personnel record on 2/9/12 at 4:05 p.m. revealed their health certificate was dated 12/01/10. 3. Review of Consultant #7's personnel record on 2/9/12 at 4:15 p.m. revealed their health certificate was dated 6/23/10. 4. Review of Consultant #8's personnel record on 2/9/12 at 4:30 p.m. revealed their health certificate was dated 7/12/10. Interview with the facility's qualified intellectual disabilities professional (QIDP) on 2/9/12, at 4:47 p.m., confirmed the health certificates for Staff #2, Staff #10, Consultant #7 and Consultant #8's were outdated.	I 206	1206 This status will be met as evidenced by: Health Certificate for staff #2 and #10 is now current and on file. Health certificate for consultant #7 and #8 is now current and on file. HR director will ensure routine of monitoring of file to ensure that document is current and available for review during survey.	2/29/12
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 227		

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY OF DEFICIENCIES (EACH DEFICIENCY REGULATORY OR LSC...)	DEFICIENCIES PRECEDED BY FULL INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
I 227	Continued From page 5 (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure all staff maintained current cardiopulmonary resuscitation (CPR) and First Aid certifications to ensure the health and safety of its residents, for two (2) of the 14 employee records reviewed. [Staff #7 and #13] The findings include: 1. Review of Staff #7's personnel record on 2/9/12, at 2:45 p.m., revealed his CPR certification expired on 12/22/21. Interview with the facility's qualified intellectual disabilities professional (QIDP) on 2/9/12, at 4:40 p.m., confirmed the CPR certification had expired. 2. Review of Staff #13's personnel record on 2/9/12, at 3:25 p.m., revealed her First Aid (FA) certification was not on record at the time of the inspection. Interview with the facility's QIDP on 2/9/12, at 4:45 p.m., confirmed the FA certification was not on record.		I 227	I227 #1, 2 This Statute will be met as evidenced by: Review of the record indicates that direct care staff receives annual CPR and First Aid training. Facility Coordinator will ensure that all staff receives training as outlined. Additional training will be provided to RD for timely follow up of staff registration for all training in accordance to standard 2/29/12
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive		I 229	I229 This Statute will be met as evidenced by: The QDDP will coordinate with psychologist to provide additional training to all staff that include medical staff providing support for individual #1.

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 229	Continued From page 7 training on how to manage Resident #1's maladaptive behaviors.	I 229	
I 261	<p>3512.2 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure their personnel records were maintained in a centralized file and made available at the time of inspection.</p> <p>The finding includes:</p> <p>On 2/7/12, at 6:30 p.m., the survey team requested that the personnel records be made available for inspection. The facility agreed to have the records available by 1:00 p.m. the following day (2/8/12). On 2/9/12, at approximately 2:30 p.m., the personnel records were provided to the survey team. At 4:15 p.m., the facility's qualified Intellectual disabilities professional (QIDP) was made aware of the following:</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Staff #7 and Staff #14 personnel records were not available for review. Staff #7 was listed on the current staff schedule and Staff #14 was working the evening shift at the time of the inspection. 2. Consultant #3's insurance expired on 12/27/10 and #6's insurance expired on 7/1/11. 	I 261	<p>I261 #1, 2, 3 and 4 2/29/12</p> <p>This statute will be met as evidenced by: The facility governing body will ensure that all pertinent record are provided to the surveyor during the survey process. The facility governing body will ensure that each professional consultant record are review periodically to ensure timely update of record The facility HR will ensure that each health certificate is review and updated prior to the expiration date. The governing body will provide routine monitoring of all record to ensure with this standard as set forth.</p>

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 229	<p>Continued From page 6</p> <p>technologies;</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to ensure nursing staff were provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for one of three residents with maladaptive behaviors. (Resident #1)</p> <p>The finding includes:</p> <p>On 2/8/12, at 8:48 a.m., observations during the morning medication administration pass revealed Resident #1 attempted to kick the nurse approximately three (3) times, but was unsuccessful. Moments later, the resident was successful in kicking the nurse one time.</p> <p>On 2/9/12, at approximately 4:45 p.m., interview with the registered nurse (RN) revealed that she had not been formally trained on how to implement Resident #1's behavior support plan (BSP). Interview with the morning and evening licensed practical nurses (LPNs #1 and #2) on 2/9/12, at approximately 3:55 p.m., revealed they both had not received formal training on Resident #1's BSP.</p> <p>Review of the in service training records on 2/9/12, at approximately 2:45 p.m., revealed that all staff direct support staff had received training Resident #1's BSP. However, at the time of the survey, there was no evidence that the facility's nursing team was provided training regarding the resident's BSP.</p> <p>At the time of the survey, there was no evidence that the GHPID's nursing staff had received</p>	I 229		

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20018		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 261	Continued From page 8 3. Consultant #4's Controlled Substance Certificate (CSC) was outdated. 4. Job descriptions were missing from fourteen of fourteen staff records reviewed. The QIDP reviewed the information and took effort to correct the problems prior to the close of survey. The QIDP contacted the human resources department and secured a copy of Staff #7 and Staff #14's personnel files. In addition, the QIDP contacted Consultant #3 and Consultant #5 and was able to secure updated insurance documents. At the time of inspection, an updated copy of Consultant #4's CSC was pending and none of the job descriptions were made available for review. The facility's Governing Body and the Human Resources Department failed to enact an effective system of implementing and managing a centralized method of record keeping to ensure the requirements listed in Title 22 DCMR 3509 [Personnel Policies].	I 261		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHPID failed to ensure staff implemented residents' behavior support plans (BSPs), for one of the three sampled residents with maladaptive behaviors. (Resident #1) The finding includes:	422	I422 This Statute will be met as evidenced by: Staff in the home will receive training on Client #1's BSP. Staff will receive additional training for all other Client's with BSP's in the home. The QDDP will be expected to periodically observe staff implementation of the Client's BSP's and review the documentation and make on shift corrections and provide feedback to staff on the implementation. The QDDP will schedule refresher training with staff if there are concerns noted in her observation	3/11/12

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 422	Continued From page 9 On 2/8/12, at approximately at 5:03 p.m., Resident #1 was observed to kick the dining table several times while eating dinner. A few seconds later, the resident was observed to hit herself two times in the face without interventions from Staff #1 who was assigned to assist her. It should be noted that Staff #1 sat directly across from the resident the entire time during dinner. Interview with Staff #1 on 2/9/12, at approximately 8:50 a.m., revealed Resident #1 had a BSP for her safety and to manage her maladaptive behaviors [i.e. physical aggression (kicking) and self-injurious behaviors (SIB)]. Further interview revealed that when Resident #1 presented with SIB, staff should ask her to calm down and move her hands away from her face. Staff #1 indicated that staff should verbally prompt Resident #1 to stop kicking when the behavior is observed and escort her to another location. When asked, Staff #1 stated that she did not document the behaviors that occurred during the dinner meal on 2/8/12. Staff #1 further acknowledged that she did not implement the BSP when Resident #1 was observed to hit herself during dinner. On 2/9/12, at 12:00 p.m., review of Resident #1's BS,P dated 6/9/11, revealed that the resident's targeted behaviors included physical aggression (kicking) and self-injurious behavior (face slapping). Further review revealed that when the resident exhibited SIB, staff should verbally direct her to calm down while simultaneously moving her hand away from her face. Continued review of the BSP revealed that "staff should verbally direct <resident's name> to calm down while simultaneously moving her hand away from her face. At the time of the survey, there was no evidence	422	

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/08/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY STATE, ZIP CODE 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) COMPLETE DATE
1422	Continued From page 10 . that staff implemented Resident #1's BSP as recommended.	1422		
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for persons with Intellectual disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one of the three residents of the GHPID. (Residents #3) The findings include: [483.470(g)(2)] The GHPID failed to furnish Resident #1's recommended adaptive equipment, as follows: On 2/9/12, at 1:44 p.m., the qualified intellectual disabilities professional (QIDP) presented a physical therapy (PT) evaluation, dated 1/12/12, in which the PT documented "the male end clip of the waist belt is missing" from Resident #3's wheelchair. The resident had not been observed using a wheelchair thus far during the survey. The PT evaluation indicated the wheelchair was used for "extended outings" in the community.	1500	1500 This Statute will be met as evidenced by: A repair request for Client #3's chair had already been submitted. The "male end of the clip" has been repaired. QDDP will ensure documentation is filed in adaptive equipment book so there is record of repairs completed for review.	2/29/12

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
I 500	Continued From page 11 When asked about the condition of the waist belt on 2/9/12, at 1:57 p.m., the QIDP retrieved Resident #3's wheelchair from the resident's bedroom. She confirmed the wheelchair was only used for extended community outings. Upon examining the belt, she determined the male end clip was indeed missing. She left the room, stating that she would make inquiries. The QIDP returned at 2:01 p.m., stating that the wheelchair vendor had been in the facility on 1/9/12. She could not, however, verify that a 719A form had been prepared by the facility and/or been forwarded to the vendor in the month since the visit. At 2:14 p.m., the QIDP was observed sending a 719A form for the aforementioned waist belt repair, via fax, to their corporate office. This is a repeat deficiency. See Federal Deficiency Report, dated 2/10/10.	I 500			

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
R 000	INITIAL COMMENTS A licensure survey was conducted from 2/7/12 through 2/9/12. A sample of three residents was selected from a population of five women and one man with profound intellectual disabilities. The findings of the survey were based on observations in the home and three day programs, interviews with direct support staff, administrative staff and one resident's father, as well as a review of resident and administrative records, including incident reports.	R 000	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the criminal background checks for all staff covered the seven year period prior to their start of employment, for two of the fourteen staff employed. (Staff #12 and Staff #13) The findings include: 1. Record review on 2/9/12, beginning at 3:00 p.m., revealed Staff #12's personnel record reflected they worked and lived in the state of New York within the seven years before their start of employment. Further review revealed the criminal background did not cover the state of New York.	R 125	R125 This Statute will be met as evidenced by: 1. The facility Human Resources has completed background check on staffs #12 and #13 as required. The Human Resources Director will ensure that job description are complete in accordance to the regulations. 2/29/12

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Jeffrey Sanku Director of Residential Services

TITLE

(X6) DATE

5/4/12

PRINTED: 02/23/2012
FORM APPROVED

Health Regulation & Licensing Administration

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 02/09/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
R 125	<p>Continued From page 1</p> <p>Interview with the facility's qualified intellectual disabilities professional (QIDP) and the house manager (HM) on 2/9/2012, at 4:16 p.m., confirmed that the criminal background check did not include the state of New York.</p> <p>2. Record review on 2/9/12, beginning at 3:15 p.m., revealed Staff #13's personnel record reflected they worked in the District of Columbia within the seven years before their start of employment. Further review revealed the criminal background did not cover the District of Columbia.</p> <p>Interview with the facility's QIDP and HM on 2/3/12, at approximately 4:21 p.m., confirmed that the criminal background check did not include the District of Columbia.</p>	R 125	