

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from 1/26/12 through 1/27/12. A sample of four clients was selected from a population of seven women with profound intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home, interviews with direct support staff and administrative staff, as well as a review of client and administrative records, including incident reports.</p>	W 000	<p><i>Renewal 3/6/12</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 159	<p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's qualified intellectual disabilities Professional (QIDP) failed to ensure the coordination, monitoring, and implementation of a clients' habilitation and planning, for one of the four sampled clients. (Client #2)</p> <p>The finding includes: On 1/27/12, at 9:15 a.m., the QIDP was asked about a lap tray that was being stored behind a recliner in the living room-dining area of the</p>	W 159	<p><b>W159</b></p> <p>This Standard will be met as evidenced by:</p> <p>The QDDP will follow-up with the PT/OT to determine when Client #2 lap tray should be used. If warranted, the QDDP will schedule a Physical Therapy/Occupational Therapy in service with Client #2 support staff to ensure they are trained on the correct usage of the lap tray. In the future the QDDP will ensure that all Clients adaptive equipment is being used as ordered and staff are trained on its use.</p>	3/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Jeffrey D. Sanchez* - Director of Residential Services  
TITLE  
DATE  
*2/2/12*

A 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: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, 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 1</p> <p>facility. The lap tray had been observed in the same location throughout the observation period on the day before. The QIDP replied that it belonged to Client #2. She retrieved the lap tray and carried it to the front foyer. Upon return, the QIDP explained that it was used to elevate the client's arms and to keep her more upright when she was observed feeling tired. At 9:35 a.m., the QIDP presented a listing of Client #2's adaptive equipment, which indicated the lap tray, was prescribed "for additional support."</p> <p>On 1/27/12, at 11:41 a.m., a staff was observed wheeling Client #2 into the facility from outside, through the side door leading from the driveway. There was no lap tray attached to her wheelchair. On the previous day (1/26/12), the client was observed at various times between 7:19 a.m. and 7:03 p.m. and at no time was her lap tray observed on her wheelchair providing support for her arms.</p> <p>On 1/27/12, at 12:20 p.m., review of Client #2's individual support plan (ISP), dated 10/21/11, confirmed that she was to have a lap tray as part of her adaptive equipment. However, the ISP did not address the functioning purpose of the lap tray and when it was to be used.</p> <p>On 1/27/12, approximately 3:10 p.m., a second interview was conducted with the QIDP. When asked who recommended the lap tray for Client #2, the QIDP responded by saying "I don't know who recommended it". The QIDP also added that she did not know whether or not the lap tray would fit the client's new wheelchair. The QIDP also stated that she did not know when the lap tray was supposed to be used. Interview with</p>	W 159			

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, 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 2 direct support staff on 1/27/12, at approximately 3:30 p.m., revealed they could not remember the last time the lap tray was used because it had been a long time.	W 159		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review, the facility's nursing staff failed to provide each client with nursing services in accordance with their needs, for two of the four clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>The facility's nursing services failed to schedule the administration of one of Client #1's medications (synthroid) to ensure compliance with physician's orders, as evidenced below:</p> <p>Upon entry on 1/26/12, at 6:14 a.m., this surveyor was informed by the overnight nurse (a licensed practical nurse, LPN) that she had already administered the morning medications to six of the seven clients. The LPN further indicated that she was about to administer Client #7's medications and that most medications were scheduled to be administered either at 6 a.m. or 7 a.m.</p>	W 331	<p>W331 This Standard will be met as evidenced by:</p> <p>Client #1's The medication time has been changed to reflect the 4 hour time lapse between the medications. Although the Pharmacist reviews the medications quarterly. The Pharmacist will be contacted to review all the clients charts to ensure that there are no contraindications.</p>	2/1/12

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, 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 331	<p>Continued From page 3</p> <p>Subsequent examination of the clients' morning medication regimens revealed that the facility's nursing services failed to schedule the administration of one of Client #1's medications at a time that would ensure compliance with her physician's orders, as follows:</p> <p>On 1/27/12, at 9:39 a.m., review of Client #1's physician order sheets (POS) for December 2011 ("orders valid for 120 days") revealed the following: "Levothyroxine Sodium 75 mcg tablet (WF: Synthroid 0.075 mg) 1 tab by mouth every day for thyroid preparation. Medication has boxed warning... No antacid; calcium; iron within 4 hours." The POS also included: "Calcium with Vitamin D 600 mg-400 tablet (WF: Caltrate 600+D) 1 tab by mouth twice daily to increase calcium absorption..."</p> <p>On 1/26/12, at 10:31 a.m., review of the client's medication administration records (MAR) for December 2011 revealed that nursing services had scheduled a 7 a.m. administration time for synthroid. Nursing services had also scheduled a 7 a.m. administration time for the Calcium with Vitamin D supplement (Note: The calcium was also scheduled for 8 p.m.) At 10:40 a.m., the RN examined the MARs, confirmed the aforementioned findings and then stated she would bring this information to the nurse practitioner's attention.</p> <p>It should be noted that the POS indicated Client #1's calcium supplement was prescribed 1/20/10 and the synthroid was prescribed 1/25/10. There was no evidence that the facility's medical team identified the timing error prior to this survey.</p>	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 454 ASTOR PLACE, 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 4  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 staff interviews and record review, the facility failed to ensure that all prescribed medications were administered in accordance with physician's orders, for one of the four clients in the sample. (Client #1)  The finding includes:  The survey was initiated on 1/26/12. Upon entry at 6:14 a.m., this surveyor was informed by the overnight nurse (a licensed practical nurse, LPN) that she had already administered the morning medications to six of the seven clients. The LPN further indicated that she was about to administer Client #7's medications and that most medications were scheduled to be administered either at 6 a.m. or 7 a.m.  The facility's registered nurse (RN) was interviewed shortly after her 10:17 a.m. arrival that morning. When informed about the timing of the morning medication administration, the RN expressed concern regarding potential drug interactions. Specifically, she noted that five of the clients received Fosamax once a week, every Thursday morning and the Fosamax should be administered "at least 30 minutes prior to other medications... for absorption."  Subsequent examination of the clients' morning medication regimens revealed that the facility's	W 368	W368 This Standard will be met as evidenced by: Client #1's The medication time has been changed to reflect the 4 hour time lapse between the medications. Although the Pharmacist reviews the medications quarterly. The Pharmacist will be contacted to review all the clients charts to ensure that there are no contraindications.	2/1/12

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, 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	<p>Continued From page 5</p> <p>nursing services failed to schedule the administration of one of Client #1's medications at a time that would ensure compliance with her physician's orders, as follows:</p> <p>On 1/27/12, at 9:39 a.m., review of Client #1's physician order sheets (POS) for December 2011 ("orders valid for 120 days") revealed the following: "Levothyroxine Sodium 75 mcg tablet (WF: Synthroid 0.075 mg) 1 tab by mouth every day for thyroid preparation. Medication has boxed warning... No antacid; calcium; Iron within 4 hours." The POS also included: "Calcium with Vitamin D 600 mg-400 tablet (WF: Caltrate 600+D) 1 tab by mouth twice daily to increase calcium absorption..."</p> <p>On 1/26/12, at 10:31 a.m., review of the client's medication administration records (MAR) for December 2011 revealed that nursing services had scheduled a 7 a.m. administration time for synthroid. Nursing services had also scheduled a 7 a.m. administration time for the Calcium with Vitamin D supplement (Note: The calcium was also scheduled for 8 p.m.) At 10:40 a.m., the RN examined the MARs, confirmed the aforementioned findings and then stated she would bring this information to the nurse practitioner's attention.</p> <p>It should be noted that the POS indicated Client #1's calcium supplement was prescribed 1/20/10 and the synthroid was prescribed 1/25/10. There was no evidence that the facility's medical team identified the timing error prior to this survey.</p>	W 368		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair,</p>	W 436		

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

(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
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1054 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	09G121			
W 436	<p>Continued From page 6</p> <p>and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD Is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's adaptive equipment was maintained in good repair, for two of the four clients in the sample. [Clients #1 and #2]</p> <p>The findings include:</p> <p>1. On 1/26/12, at 7:28 a.m., observation of Client #1's wheelchair revealed black tape used to cover damage to the cushion on the right armrest. Continued observations revealed significant damage to the material across the front edge of the foot box.</p> <p>On 1/27/12, at 1:40 p.m., the house manager (HM) stated "we just put in paper work for Client #1's wheelchair." She presented the facility's Adaptive Equipment binder. There was a 719A form, dated 5/26/11. Attached was a wheelchair evaluation form, signed by the physical therapist on 5/26/11, that reflected "right armrest cushion worn...footrest/ footboard intact... recommend new right arm rest cushion..." Continued interview with the HM revealed that 719A forms and relevant documentation routinely were submitted to the facility's corporate office for additional processing. There was no evidence if/when the 5/26/11 form was completed and</p>	W 436	<p>W436 This Standard will be met as evidenced by: Client #1's foot box had been replaced. The PT has indicated that the new foot box needed to be adjusted. The QDDP for the home has submitted the required 719A form for the adjustments and the repair of the arm rest. The QDDP will continue to follow-up on a weekly basis to ensure the acquisition of Client #1 repairs. The QDDP will ensure the Adaptive Equipment Repair is completed by the technician or specialist every time equipment is repaired.</p>	3/14/12

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

PRINTED: 02/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, 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 436	<p>Continued From page 7 forwarded to a wheelchair vendor.</p> <p>The Adaptive Equipment binder held another 719A form (largely blank) dated 11/17/11. Attached was a Wheelchair Assessment: Acquisition, Replacement, Modification and Repair form, signed by the qualified intellectual disabilities professional (QIDP) on 11/17/11. The QIDP documented "repair right armrest cushion" was needed. The form did not reflect the condition of the footrest/ footboards (space was left blank).</p> <p>However, on 1/27/11, at 3:39 p.m., review of Client #1's physical therapy (PT) records revealed that on 10/3/11, the PT had documented "foot box cushions worn" and on 11/15/11 "the foot boxes need to be moved medially to prevent her feet from falling between the foot boxes." [Note: The PT did not mention the right armrest cushion.]</p> <p>Continued record review on 1/27/11 failed to show evidence that Client #1's wheelchair needs had received further attention. At 4:00 p.m., the QIDP confirmed, there had been no follow-up in the two months since the paperwork was submitted on 11/17/11.</p> <p>This is a repeat deficiency. See Federal Deficiency Report, dated 11/17/11.</p>	W 436		
-------	--	-------	--	--

PRINTED: 02/10/2012  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, 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
--------------------	--	---------------	---	--------------------

1 000 INITIAL COMMENTS

A licensure survey was conducted from 1/26/12 through 1/27/12. A sample of four residents was selected from a population of seven women with profound intellectual disabilities.

The findings of the survey were based on observations in the home, interviews with direct support staff and administrative staff, 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.]

1 000

1 090 3504.1 HOUSEKEEPING

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 and interview, the group home for persons with intellectual disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for seven of the seven residents of the facility. (Residents #1, #2, #3, #4, #5, #6 and #7)

The findings include:

1. On 1/26/12, at 8:17 a.m., the front right leg of a dining room chair wobbled when weight was applied; the chair was about to collapse under

1 090

1090

This Statute will be met as evidenced by:

1. The two chairs in the home will be repaired
2. The blinds will be replaced
3. The debris has been removed from around the home.
4. The door step has been secured to the door

The Residence Director for the home will complete the maintenance report for the home and report and concerns noted in a timely fashion.

3/14/12

Health Regulation & Licensing Administration  
*Tiffany J. Services - Director of Residential Services*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE 2/20/12 (X9) DATE



PRINTED: 02/10/2012  
FORM APPROVED

## Health Regulation &amp; Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, 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>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 four residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On 1/27/12, at 9:15 a.m., the QIDP was asked about a lap tray that was being stored behind a recliner in the living room-dining area of the GHPID. The lap tray had been observed in the same location throughout the observation period on the day before. The QIDP replied that it belonged to Resident #2. She retrieved the lap tray and carried it to the front foyer. Upon return, the QIDP explained that it was used to elevate the resident's arms and to keep her more upright when she was observed feeling tired. At 9:35 a.m., the QIDP presented a listing of Resident #2's adaptive equipment, which indicated the lap tray, was prescribed "for additional support."</p> <p>On 1/27/12, at 11:41 a.m., a staff was observed wheeling Resident #2 into the GHPID from outside, through the side door leading from the driveway. There was no lap tray attached to her wheelchair. On the previous day (1/26/12), the resident was observed at various times between 7:19 a.m. and 7:03 p.m. and at no time was her lap tray observed on her wheelchair providing support for her arms.</p> <p>On 1/27/12, at 12:20 p.m., review of Resident #2's individual support plan (ISP), dated 10/21/11, confirmed that she was to have a lap tray as part of her adaptive equipment. However, the ISP did not address the functioning purpose of the lap tray and when it was to be used.</p>	180			

PRINTED: 02/10/2012  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, 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  On 1/27/12, approximately 3:10 p.m., a second interview was conducted with the QIDP. When asked who recommended the lap tray for Resident #2, the QIDP responded by saying "I don't know who recommended it". The QIDP also added that she did not know whether or not the lap tray would fit the resident's new wheelchair. The QIDP also stated that she did not know when the lap tray was supposed to be used. Interview with direct support staff on 1/27/12, at approximately 3:30 p.m., revealed they could not remember the last time the lap tray was used because it had been a long time.  At the time of the survey, the QIDP failed to provide evidence that indicated when/if Client #2's lap tray was to be used.	I 180		
I 379	3519.10 EMERGENCIES  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.  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 ensure that all incidents that present a risk to residents' health and well-being were reported immediately and in writing to the	I 379	I 379 This statute will be met as evidenced by: The QDDP for the home will be retained on incident reporting. It is the expectation that the QDDP report all unusual incidents according to the established policies and procedures.	8/14/12

PRINTED: 02/10/2012  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE SE WASHINGTON, DC 20015
--	--

(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
--------------------	--	---------------	---	--------------------

1379	<p>Continued From page 4</p> <p>Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the seven residents of the GHPID. [Resident #1]</p> <p>The finding includes:</p> <p>On 1/26/12, at 6:48 a.m., review of Incident reports in the GHPID revealed that on 1/12/12, Resident #3 experienced a seizure while she was on a medical appointment. The clinic staff sent her to the emergency room for evaluation and treatment. The incident report documented that HRLA was notified of the incident on 1/17/12. The facility's qualified intellectual disabilities professional was asked about the incident during the Entrance Conference. At 11:15 a.m., she acknowledged that the incident was not reported immediately to HRLA.</p>	1379		
------	--	------	--	--

1401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>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.</p> <p>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 professional services that included 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, for two of the four residents in the sample. (Resident #1)</p>	1401	<p>1401</p> <p>This statute will be met as evidenced by: Client #1's The medication time has been changed to reflect the 4 hour time lapse between the medications. Although the Pharmacist reviews the medications quarterly. The Pharmacist will be contacted to review all the clients' charts to ensure that there are no contraindications.</p>	2/1/12
------	---	------	--	--------

PRINTED: 02/10/2012  
FORM APPROVED

## Health Regulation &amp; Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, 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 401	<p>Continued From page 5</p> <p>The finding includes:</p> <p>The GHPID's nursing services failed to schedule the administration of one of Resident #1's medications (synthroid) to ensure compliance with physician's orders.</p> <p>Upon entry on 1/26/12, at 6:14 a.m., this surveyor was informed by the overnight nurse (a licensed practical nurse, LPN) that she had already administered the morning medications to six of the seven residents. The LPN further indicated that she was about to administer Resident #7's medications and that most medications were scheduled to be administered either at 6 a.m. or 7 a.m.</p> <p>Subsequent examination of the residents' morning medication regimens revealed that the facility's nursing services failed to schedule the administration of one of Resident #1's medications at a time that would ensure compliance with her physician's orders, as follows:</p> <p>On 1/27/12, at 9:39 a.m., review of Resident #1's physician order sheets (POS) for December 2011 ("orders valid for 120 days") revealed the following: "Levothyroxine Sodium 75 mcg tablet (WF: Synthroid 0.075 mg) 1 tab by mouth every day for thyroid preparation. Medication has boxed warning... No antacid; calcium; Iron within 4 hours." The POS also included: "Calcium with Vitamin D 600 mg-400 tablet (WF: Caltrate 600+D) 1 tab by mouth twice daily to increase calcium absorption..."</p> <p>On 1/26/12, at 10:31 a.m., review of the resident's medication administration records</p>	I 401		

PRINTED: 02/10/2012  
FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/27/2012
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, 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 401	Continued From page 6  (MAR) for December 2011 revealed that nursing services had scheduled a 7 a.m. administration time for synthroid. Nursing services had also scheduled a 7 a.m. administration time for the Calcium with Vitamin D supplement (Note: The calcium was also scheduled for 8 p.m.) At 10:40 a.m., the RN examined the MARs, confirmed the aforementioned findings and then stated she would bring this information to the nurse practitioner's attention.  It should be noted that the POS indicated Resident #1's calcium supplement was prescribed 1/20/10 and the synthroid was prescribed 1/25/10. There was no evidence that the facility's medical team identified the timing error prior to this survey.	I 401			