

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

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0351

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2012
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from 3/8/12 through 3/8/12. A sample of two clients was selected from a population of three men with moderate 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 and one day program, interviews with direct support staff, administrative staff and one client, as well as a review of client and administrative records, including incident reports.</p>	W 000	<p><i>Received 4/6/12</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its established policy for investigating allegations of abuse, for one of one client involved in an allegation of verbal abuse. (Client #1)</p> <p>The finding includes:</p> <p>[Cross-refer to W154] On 3/8/12, beginning at 1:37 p.m., review of an investigation report that was generated by an outside agency and dated 11/3/11, revealed that on 11/2/11, Client #1 had</p>	W 149	<p>W149 Standard will be met as evidenced by:</p> <p>IMC submitted the report and investigation and in the future the IMC will investigate the incident in a timely fashion.</p>	3/8/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Director of Residential Services	(X6) DATE 4/2/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	<p>Continued From page 1</p> <p>an accident on the floor in his bedroom. The next day, the client was transported to the day program where he was asked by day program staff about a fresh bite mark to his wrist. According to the investigation report, the client stated that he was upset because staff at his home had told him to clean that "s***" up off the floor. There was no evidence, however, that the facility had conducted an internal investigation.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 3/8/12, at 3:00 p.m., revealed that on 11/2/12, Client #1 had an accident in his bedroom. The QIDP further confirmed that the client told his day program staff on the next day, that he bit his wrist because he was upset that staff at the home told him the clean that "s***" off the floor. The QIDP stated that the day program had written the initial incident report characterizing the incident as verbal abuse by staff at the group home. According to the QIDP, the staff who allegedly verbally abused Client #1 was immediately placed on administrative leave.</p> <p>When asked if the facility had conducted an internal investigation to determine if the allegation of verbal abuse had occurred, the QIDP indicated "the incident management coordinator (IMC) took the lead on this incident" and she would therefore, have to consult with him. She stated that according to their policy on incident management, this incident should have been investigated.</p> <p>Review of the incident management policy (IMP) on 3/8/12, at approximately 4:25 p.m., revealed that the facility's policies categorized an allegation</p>	W 149			

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W 149	Continued From page 2 of abuse as a "Serious Reportable Incident." Further review of the policy revealed that the facility would provide evidence that all alleged violations were thoroughly investigated. However, no additional information or evidence of an internal investigation report was presented before the survey ended later that afternoon.	W 149		
W 154	At the time of the survey, there was no documented evidence that the facility thoroughly investigated the allegation of verbal abuse, in accordance with its policies and procedures. 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation into an allegation of verbal abuse, for one of one client involved in an allegation of verbal abuse. (Client #1) The finding includes: [Cross-refer to W149] On 3/6/12, beginning at 1:37 p.m., review of an investigation report that was generated by an outside agency and dated 11/3/11, revealed that on 11/2/11, Client #1 had an accident on the floor in his bedroom. The next day, the client was transported to the day program where he was asked by day program staff about a fresh bite mark to his wrist. According to the investigation report, the client stated that he was upset because staff at his	W 154	W154 Standard will be met as evidenced by: Refer to W149	3/8/12

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W 154	<p>Continued From page 3</p> <p>home had told him to clean that "s****" up off the floor. There was no evidence, however, that the facility had conducted an internal investigation.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 3/8/12, at 3:00 p.m., revealed that on 11/2/11, Client #1 defecated on himself while in his bedroom. The QIDP further confirmed that the client told his day program staff on the next day, that he bit his wrist because he was upset that staff at the home told him the clean that "s****" off the floor. The QIDP stated that the day program had written the initial incident report characterizing the incident as verbal abuse by staff at the group home. According to the QIDP, the staff who allegedly verbally abused Client #1 was immediately placed on administrative leave.</p> <p>When asked if the facility had conducted an internal investigation to determine if the allegation of verbal abuse had occurred, the QIDP indicated "the incident management coordinator (IMC) took the lead on this incident" and she would therefore, have to consult with him. She stated that according to their policy on incident management, this incident should have been investigated.</p> <p>At the time of the survey, there was no documented evidence that the facility thoroughly investigated the allegation of verbal abuse, in accordance with its policies and procedures.</p>	W 154		
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative</p>	W 156		

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W 156	Continued From page 4 or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator within five working days of the incident, for three of the three clients residing in the facility. (Clients #1, #2 and #3) The findings include: Review of the facility's incident reports and corresponding investigation reports on 3/6/12, beginning at 1:37 p.m., revealed the following investigations that were not reported to the administrator within five working days: 1. An incident (allegation of abuse-exploitation) report dated 7/8/11, documented that a direct support person working with Client #3 discovered that the client's Wii game with a foot pad console was missing from underneath the client's bed. Review of the corresponding investigative report revealed the incident management coordinator (IMC) completed the investigation on 9/13/11. Further review revealed the administrator reviewed and signed the investigative report on 9/22/11, more than two months after the client's belongings were reported missing. 2. An incident report dated 1/17/12 documented that Client #2 was discovered with a bruise on the right side of his face. Review of the corresponding investigative report (not dated) showed no evidence that the investigative findings had been the reported to the	W 156	W156 Standard will be met as evidenced by: 1. The QDDP has developed a data sheet and log in book where staff will visually observe the presence of the Wii machine on each shift and write their initials to indicate that the machine is actually there. 2. The QDDP or designee will report all incidents to DRS and COO. The IMC will ensure that all investigation will be signed off on by the administrator after completed. DRS will train all agency QDDP's on the process for completing investigations.	3/18/12 4/12/12

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W 156	Continued From page 5 administrator. Interview with the qualified Intellectual disabilities professional (QIDP), on 3/8/12, at approximately 2:55 p.m., confirmed that the aforementioned incidents had not been reviewed by the facility's administrators. At the time of the survey, there was no documented evidence that the results of all investigations were reported to the administrator within five working days of the incident.	W 156		
W 242	This is a repeat deficiency. See Federal Deficiency Report dated 2/10/11. 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills (hand washing), for one the two clients (Client #1) included in the sample. The finding includes: On 3/6/12, beginning at 2:32 p.m., Client #1 was	W 242	W242 Standard will be met as evidenced by: QDDP will conduct a training on hand washing and train person #1 on hand washing after task. QDDP will work with client # 1 to create a program to ensure appropriate hand washing. QDDP's will assess the skills of the other Individual's in the home and develop a training program if necessary.	4/12/12

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W 242	<p>Continued From page 6</p> <p>observed in his home. From 2:45 p.m. until 3:15 p.m., Client #1 was observed working on his computer and utilizing his I-Pod. At 3:15 p.m., he was observed to retrieve dirty clothes from a white bag and he informed the residential director that the clothes needed to go to the cleaners. At 3:21 p.m., the client ambulated (using crutches) from his bedroom to the dining table where he was given popcorn for a snack. The client proceeded to eat the popcorn with his hands. At no time was he observed to wash his hands.</p> <p>At 4:06 p.m., Client #1 was back in his bedroom surfing the internet. At 5:20 p.m., he and his peers were served dinner which consisted of barbecue chicken, baked beans, and shredded salad dressing. Again, he was not observed to wash his hands prior to eating. Similar observations were made again on 3/7/12, at approximately 5:25 p.m., when he did not wash his hands prior to dinner.</p> <p>Interview with Client #1 on 3/6/12 and 3/7/12, at 4:27 p.m. and 6:42 p.m. respectively, revealed that he did not wash his hand prior to snack and dinner time. The client stated that staff "forgot to remind me." He also stated that he only washed his hands after using the bathroom. When asked, Client #1 stated that he had not received any formal/informal training on hand washing.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 3/8/12, at approximately 4:53 p.m., revealed that Client #1 did not have a formal training objective program on hand washing. The QIDP stated that Client #1 was more than capable of attending the trainings on infection control (hand washing) that were</p>	W 242		

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W 242	Continued From page 7 provided for direct support staff. She also added that the client would benefit from a hand washing program. On 3/8/12, at 9:26 a.m., review of Individual Client #1's program plan (IPP) dated 2/29/12 failed to provide evidence of a training objective to assist the client with washing his hands before eating meals. At the time of the survey, there was no documented evidenced Client #1 received training to address the need of hand washing.	W 242		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility's nursing staff failed to provide each client with nursing services in accordance with their needs, for one of the three clients residing in the facility. (Client #3) The finding includes: The evening medication administration was observed on 3/8/12 from 5:44 p.m. - 6:06 p.m. On 3/7/12, beginning at 8:10 a.m., verification of the clients' medication regimens revealed that Client #3's evening medications were scheduled at three different times every evening (5 p.m., 7 p.m. and 8 p.m.) yet they had been observed being administered together by one nurse, concurrently on the previous evening.	W 331	W331 Standard will be met as evidenced by: RN will train the Nursing Coordinator and the LPN on medication administration and time frames for the administration of the medication. The RN will conduct periodic monitoring on the medication administration.	4/12/12

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W 331	<p>Continued From page 8</p> <p>The facility's licensed practical nurse (LPN) coordinator was interviewed in the facility on 3/7/12 from 2:57 p.m. - 3:22 p.m. The LPN Coordinator indicated that it was his responsibility to review the clients' physician's orders and assign the designated administration times for all medications on each client's medication administration records (MARs). He reviewed Client #3's March 2012 MAR and confirmed the following:</p> <ul style="list-style-type: none"> - "Polyethylene Glycol 17 gm/1 dose powder (WF: Miralax) dissolved in liquid by mouth every day for bowel regimen" was scheduled for 5 p.m. administration daily. - "Famotidine 20 mg tablet (WF: Pepcid U-U F/C) 1 tab by mouth at bedtime for GI distress" was scheduled for 8 p.m. administration daily. - Client #3's other prescribed medications were designated to be administered either at 7 a.m. and/or at 7 p.m. <p>Further interview with the LPN Coordinator revealed that one nurse was scheduled to administer the evening medications, once per evening. He stated that standard nursing practices allow for the administration of prescribed medications anywhere from 1 hour before the designated time up to 1 hour after the designated time. He then acknowledged that as currently scheduled (3 hours apart), a nurse would not be able to administer Client #3's medications timely in accordance with standard nursing practices.</p> <p>During the Exit conference on 3/8/12, at</p>	W 331		
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W331	Continued From page 9 approximately 5:10 p.m., the facility's registered nurse stated that she would review Client #3's medication regimen with the primary care physician and ensure that the LPN Coordinator would schedule administration times accordingly.	W331		
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1 000	INITIAL COMMENTS A licensure survey was conducted from 3/6/12 through 3/8/12. A sample of two residents was selected from a population of three men with moderate intellectual disabilities. The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, administrative staff and one resident, as well as a review of resident and administrative records, including incident reports.	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 three of the three residents of the facility. (Residents #1, #2 and #3) The findings include: 1. On 3/6/12, at 2:50 p.m., observation of the wooden railing in the dining room revealed that most of the molding used to cover the screws that secure the base of the railing's support posts to the floor were missing (leaving the screws exposed). In addition, 1 of the 7 posts was missing from the railing.	1 090	1 090 This statute will be met as evidenced by: 1. The Director of Maintenance has fixed the railing. 2. The Director of Maintenance has repaired the mold and mildew stains around the bathtub and toilet and has replaced the worn chalking. 3. The Director of Maintenance has removed the lint buildup from the outside lint vent. The RD will conduct daily walk thru's and report any concerns to the Director of Maintenance in a timely fashion.	3/15/12

Health Regulation & Licensing Administration

Theresa J. Sombers Director of Residential Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE 4/2/12

(X6) DATE

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I 090	Continued From page 1 2. On 3/8/12, at 4:00 p.m., mold and mildew stains were observed on cracked caulking around the upper and lower edges of the bathtub located in the bathroom adjacent to Resident #3's bedroom. Similar cracked, stained caulking was observed around the base of the toilet in the same bathroom. 3. On 3/8/12, at 4:10 p.m., lint was observed in the exhaust vent leading outdoors from the clothes dryer. The build-up of lint presented a potential fire hazard. The residential director who was present at the time, verified the aforementioned maintenance needs. He assured the surveyors that he would notify their maintenance engineer immediately to request that the vent from the dryer be cleaned of all lint.	I 090		
I 104	3504.11 HOUSEKEEPING Each GHMRP shall maintain at least one (1) additional set of the linens specified in §3504.10 for each resident. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with Intellectual disabilities (GHPID) failed to furnish additional linen sets (i.e. 2 sheets, 1 pillow case, 1 bath towel, 1 hand towel and 1 wash cloth), for three of the three residents of the GHPID. (Residents #1, #2 and #3) The findings include: 1. On 3/8/12, at 3:55 p.m., observation of	I 104	II04 Statute will be met as evidenced by: 1. The RD has requested the funds to replace the personal funds spent from the Individuals money and those funds will be reimbursed to their personal accounts. 2. The RD will purchase a second set of bed linens with the company funds. 3. The RD will request funds from the company to purchase hand towels, pillow cases and wash clothes.	

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018		
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I 104	Continued From page 2 Resident #2's bedroom revealed that there was one comforter and a set of sheets with pillow case on his bed. The RD stated that these were the items that were purchased on 11/1/11. The RD further indicated that there was no other set of bed linens available for Resident #2's use. The GHPID's management reportedly approved a request for funds that was submitted on 2/29/12; however, the RD had not yet received the funds. 2. Similarly, observations just minutes later of Residents #1 and #3's beds revealed that they were using the comforters and bed sheets that were purchased on 11/1/11, and they too were without a second set of bed linens. The RD stated that all three residents were to go shopping once the funds were received from the facility's corporate office. 3. On 3/8/12, at 4:00 p.m., observation of the residents' linen supplies revealed: a. no evidence of hand towels; b. there were no extra pillow cases available; and, c. the six wash clothes that were available were frayed, torn and worn. The RD, who was present during the environmental walk-thru, verified that the residents' bath linens were in poor condition and indicated that they would purchase new bath linens once the recently-requested funds were received from the corporate office.	I 104		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire	I 420		

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I 420	<p>Continued From page 3</p> <p>and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</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 evidence each resident was provided with habilitation and training to enable them to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning, for one of the two residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>On 3/6/12, beginning at 2:32 p.m., Resident #1 was observed in his home. From 2:45 p.m. until 3:15 p.m., Resident #1 was observed working on his computer and utilizing his I-Pod. At 3:15 p.m., he was observed to retrieve dirty clothes from a white bag and he informed the residential director that the clothes needed to go to the cleaners. At 3:21 p.m., the resident ambulated (using crutches) from his bedroom to the dining table where he was given popcorn for a snack. The resident proceeded to eat the popcorn with his hands. At no time was he observed to wash his hands.</p> <p>At 4:06 p.m., Resident #1 was back in his bedroom surfing the internet. At 5:20 p.m., he and his peers were served dinner which consisted of barbecue chicken, baked beans, and shredded salad dressing. Again, he was not observed to wash his hands prior to eating. Similar observations were made again on 3/7/12, at approximately 5:25 p.m., when he did not wash</p>	I 420	<p>I420</p> <p>Statute will be met as evidenced by: QDDP will conduct a training on hand washing and train person #1 on hand washing after task. QDDP will work with client # 1 to create a program to ensure appropriate hand washing. QDDP's will assess the skills of the other Individual's in the home and develop a training program if necessary. The QDDP will periodically monitor all Individuals to ensure proper handwashing</p>	2/12/12

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1420	Continued From page 4 his hands prior to dinner. Interview with Resident #1 on 3/6/12 and 3/7/12, at 4:27 p.m. and 6:42 p.m. respectively, revealed that he did not wash his hand prior to snack and dinner time. The resident stated that staff "forgot to remind me." He also stated that he only washed his hands after using the bathroom. When asked, Resident #1 stated that he had not received any formal/informal training on hand washing. Interview with the qualified intellectual disabilities professional (QIDP) on 3/8/12, at approximately 4:53 p.m., revealed that Resident #1 did not have a formal training objective program on hand washing. The QIDP stated that Resident #1 was more than capable of attending the trainings on infection control (hand washing) that were provided for direct support staff. She also added that the resident would benefit from a hand washing program. On 3/8/12, at 9:26 a.m., review of Individual Resident #1's program plan (IPP) dated 2/29/12 failed to provide evidence of a training objective to assist the resident with washing his hands before eating meals. At the time of the survey, there was no documented evidenced Resident #1 received training to address the need of hand washing.	1420		
1500	3523.1 RESIDENTS 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.	1500	I500 Statute has been met as evidenced by: The RD has requested company funds to reimburse the individuals and the money will be placed into their personal accounts. IDI QDDP's and RD's will be retained on handling Individual's funds	4/12/12

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1500	Continued From page 5 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 8, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one the the two residents in the sample. (Resident #2) The finding includes: [Cross-refer to I104] On 3/8/12, at 3:45 p.m., review of Resident #2's financial records revealed that he purchased a new comforter and a set of sheets on 11/1/11. The records showed no evidence that the resident had been reimbursed for the \$36.47 purchase. The residential director (RD) was queried about the 11/1/11 purchase on 3/8/12, at approximately 3:50 p.m. He confirmed that the resident had used \$36.47 of his own funds to purchase the aforementioned linens. He indicated that all three residents had used personal funds to purchase new bed linens after the GHPID became infested with bed bugs. At 4:04 p.m., the RD acknowledged that the GHPID was responsible for furnishing its residents with two sets of bedding. The RD confirmed that to date, the GHPID had not reimbursed the three residents for their personal funds used that day on linens.	1500			