

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

PRINTED: 08/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G191	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 2683 36TH STREET, SE WASHINGTON, DC 20024
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W 000	INITIAL COMMENTS An recertification survey was conducted from August 5, 2010, through August 6, 2010, utilizing the fundamental survey process. A random sample of two clients was selected from a population of four males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients, family members and/or legal guardians were informed of the risks and benefits of restrictive programs and supports, for one of the two clients included in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2's guardian for sedation during a medical	W 124	W124 This Standard will be met as evidenced by: The informed consent for person #2 for sedation during a medical appointment was signed and approved by the legal guardian. This has been verified with the guardian and documentation completed to support this information. Each time the QMRP/Home Manager and Nursing staff will review all components of the document carefully each time a consent is reviewed with the family and/or legal guardian to ensure compliance with this standard. Informed consent had been obtained for the BSP dated September 13, 2009. It is not clear why this information was not available for review during the survey period.	8.27.10 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ DATE 9/2/10

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 124	<p>Continued From page 1</p> <p>appointment as evidenced below:</p> <p>During the entrance conference on August 5, 2010, beginning at 10:10 a.m., house manager (HM) and licensed practical nurse (LPN) indicated that Client #2 had a court appointed legal guardian to assist the client in making health care decisions.</p> <p>Review of Client #2's physician orders (POS) on August 5, 2010, beginning at 2:45 p.m., revealed an order for Chloral Hydrate 1 gm, by mouth, one dose, for a dental appointment.</p> <p>Review of Client #2's medication administration record (MAR), confirmed that the client was administered the aforementioned sedation. Further record review revealed a signed consent. However the consent form was not checked to indicate whether the guardian consented or not. Interview with the HM and qualified mental retardation professional (QMRP) on August 6, 2010, at approximately 11:30 a.m., indicated that the guardian was usually in agreement with signing consent for the client's sedation.</p> <p>Review of Client #2's Psychological Assessment dated September 13, 2009, on August 6, 2010, at approximately 12:15 p.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that informed consent had been obtained for the use of the sedation.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or</p>	W 124	<p>The QMRP will continue to ensure that both the person and/or guardian/family members are informed of the potential risks/benefits involved in using medication, the right to refuse treatment.</p>	
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(04) 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)	(05) COMPLETION DATE
W 124	Continued From page 2 family members.	W 124	W148	
W 148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that injuries of unknown origin were reported to clients guardians, for one of four clients residing in the facility. (Client #2)</p> <p>The findings include:</p> <p>An interview was conducted with the house manager (HM) on August 5, 2010, at 10:10 a.m., during the entrance conference, to ascertain information regarding the facility's incident management system. According to the HM, all incidents should be reported to the administrator, family members and/or guardians and governmental agencies. Further interview revealed Client #2 had legal guardians that were involved in his habilitation and care. The facility's incident reports and corresponding investigations were reviewed on the same day, beginning at 9:05 a.m. and revealed the following:</p> <p>1. On November 28, 2009, staff discovered an open sore on Client #2's right elbow. According to the incident report the licensed practical nurse (LPN) initially observed the sore on the client's elbow on November 21, 2009. The LPN called the primary care physician and was instructed to</p>	W 148	<p>This Standard will be met as evidenced by:</p> <p>The Incident Management Coordinator will conduct additional staff training on reporting and documenting incidents. The QMRP must review and ensure that all incidents are reported to the administrator family members and/or guardians as well as government agencies. The Incident Management Coordinator will conduct further oversight of all incidents to ensure notifications have been completed in accordance to standard.</p>	8.31.10 ongoing

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W 148	<p>Continued From page 3</p> <p>clean the client's elbow and scheduled an appointment for two day later.</p> <p>Interview with the HM on August 5, 2010, at approximately 12:10 p.m., indicated that he was not sure if the guardian had been notified.</p> <p>2. Reconciliation of the medication administration on August 5, 2010, at approximately 9:50 a.m., revealed an incident report in the medication administration record. The incident report was dated May 14, 2010, for Client #2. The report indicated that staff discovered a bruise on the client's lower back, above his waist.</p> <p>Interview with the QMRP on August 5, 2010, at approximately 12:30 p.m., revealed that he was not aware of Client #2's injury and believed it was an error. Therefore, notifications were not made to client's guardian, as required by the agency's policy.</p>	W 148	<p>2. Reference response to #1. The Incident Manager will conduct additional staff training for nurses and staff. QMRP will review individual medical records on an ongoing basis, meet weekly with the medical staff to ensure that all documented incidents are reported in accordance to standard.</p> <p>QMRP/Home Manager/RN will continue to emphasize the importance of timely reporting and provide feedback and direction to staff as needed.</p>	Ongoing
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of the client's records, the facility failed to ensure that injuries of unknown origin were reported immediately to the administrator and to the State agency, for one of the two clients included in the sample. (Client #2)</p>	W 153	<p>The Incident Manager will also continue to conduct regular record reviews, monitoring/review of incidents for accuracy and timely reporting, trending and tracking.</p>	

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W 153	<p>Continued From page 4</p> <p>The finding includes:</p> <p>Reconciliation of the medication administration on August 5, 2010, at approximately 9:50 a.m., revealed an incident report in the medication administration record. The incident report was dated May 14, 2010, for Client #2. The report indicated that staff discovered a bruise on the client's lower back, above his waist.</p> <p>Interview with the QMRP on August 5, 2010, at approximately 12:30 p.m., revealed that he was not aware of Client #2's injury and believed it was an error. therefore, notifications were not made to the administrator or Department of Health (DOH), as required by the agency's policy.</p> <p>2. Review of the facility's unusual incident reports (UIR) and investigative reports on August 5, 2010, beginning at 9:05 a.m. revealed an incident report and investigative report for Client #2 dated June 16, 2010. The incident report indicated that a medication error occurred on June 16, 2010 at 7:00 p.m. According to the incident report the administrator was notified on June 29, 2010 (13 days later).</p> <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) August 5, 2010, at approximately 11:30 a.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents should be reported to the administrator, immediately. The QMRP confirmed that the administrator was not notified immediately, as required per agency's policy.</p>	W 153	<p>W153</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Reference responses to W148. 2. Incident Management Coordinator will conduct additional staff training as outlined. The Incident Management Coordinator will continue to review all incident reports for accuracy and timely reporting notifications. 	8.31.10 ongoing
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 154		

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W 154 Continued From page 5

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 ensure all injuries of unknown origin were investigated, for one of two clients in the sample. (Client #2)

The finding includes:

Review of the facility's unusual incident reports (UIR) and investigative reports on August 5, 2010, beginning at 9:05 a.m., revealed on November 28, 2009, staff discovered an open sore on Client #2's elbow. According to the incident report the licensed practical nurse (LPN) initially observed the sore on the client's elbow on November 21, 2009. The LPN called the primary care physician and was instructed to clean the client's elbow and scheduled an appointment for two days later.

Interview with the house manager on August 5, 2010, at approximately 11:00 a.m., indicated that the Incident Management Coordinator investigates all injuries of unknown origin. Further interview revealed, the HM confirmed that an investigation was not completed for the aforementioned incident.

W 154

W154

This Standard will be met as evidenced by:

The QMRP is responsible for reporting and completing incident investigations. In the absence of the QMRP the Incident Management Coordinator will complete investigations.

The Incident Management Coordinator will continue to oversee the incident management process, conduct training, provide trend analyzes and implement follow-up actions to ensure compliance with this standards.

Also, reference responses to W148.

8/31/10
Ongoing

W 192 483.430(e)(2) STAFF TRAINING PROGRAM

For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.

W 192

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W 192	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that staff followed client's meal time protocol and physician orders, for one of the two clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On August 5, 2010, at 4:05 p.m., direct care staff was observed preparing Client #1's dinner. The meal consisted of ham, salad, cabbage and macaroni and cheese. The salad, cabbage and macaroni and cheese were cut into bite size pieces and the ham was finely chopped.</p> <p>Interview with the direct care staff, who prepared the client's meal on August 5, 2010, at 6:30 p.m., indicated that Client #1 was on a finely chopped diet. Review of the client's current physician orders dated June 2010, revealed a diet order of finely chopped, high fiber 1700 calorie diet.</p> <p>On August 5, 2010, at approximately 6:50 p.m., interview with the license practical nurse revealed that if a client is ordered a finely chopped diet, they should not receive bite sized pieces of food.</p> <p>Review of the facility's in-service training records on August 6, 2010, at approximately 3:00 p.m., revealed that all staff had received training on Client #1's mealtime protocol on July 15, 2010. However, there was no evidence that training had been effective.</p>	W 192	<p>W192</p> <p>This Standard will be met as evidenced by:</p> <p>QMRP/Home Manager will conduct training on adherence to the mealtime protocols. The QMRP/Home Manager will continue to monitor meal preparation and mealtimes to ensure that staff are able to implement and follow mealtime protocols in compliance with physician orders for all of the people. QMRP/Home Manager will implement additional corrective actions (to include but not limited to training, disciplinary actions, IDT meetings) as needed to ensure ongoing compliance with this standard.</p>	8.13.10 ongoing
W 237	<p>483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify the type of data and</p>	W 237		

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W 237	<p>Continued From page 7</p> <p>frequency of data collection necessary to be able to assess progress toward the desired objectives.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) specified the type of data necessary to assess progress toward the desired objective, for one of two clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Observations on August 5, 2010, at 6:10 p.m., revealed Client #2 was participating in an exercise program. The exercises consisted of knee kicks and sit-to-stand bends. Interview with the house manager on August 6, 2010, at approximately 11:00 a.m., indicated that the client participates in an exercise program. Review of the IPP dated September 14, 2009, on August 5, 2010, at 12:30 p.m., revealed the following program objective: "Given verbal prompts, [the client] will participate in a formal exercise program to include bridging, sit-to-stand, knee kicks and marching, 10 repetitions, 4 days a week, for 80% of the trials etc...."</p> <p>According to the data sheets, staff documented the level of assistance needed to perform the exercises. The data sheet did not reflect the number of repetitions completed. It could not be determined how these goals were being measured for progress. Interview with the Qualified Mental Retardation Professional (QMRP) on August 6, 2010, at 12:50 p.m., acknowledged that the current data collection</p>	W 237	<p>W237</p> <p>This Standard will be met as evidenced by:</p> <p>The QMRP will receive additional training to include: IPP, training programs, frequency, data collection, measurable objectives, modifications, and assessment of progress aimed at achieving the expected outcomes. DRS will conduct random record reviews and provide feedback and direction for the QMRP to ensure QMRP is able to demonstrate skill and competency outlined to ensure continuous active treatment.</p>	<p>8/27/10 ongoing</p>
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W 237	Continued From page 8 system did not provide accurate measurement on the client's progress.	W 237	W249	
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to provide continuous active treatment, for one of the two client included in the sample. (Client #1)</p> <p>The findings include:</p> <p>1. On August 5, 2010, at 4:15 p.m., a direct care staff was observed verbally offering Client #1 snacks. At 4:25 p.m., Client #1 was observed sitting at the dining room table. After several minutes, the client stood up and went into the kitchen, looked around and returned to the dining room table. Direct care staff continued to verbally prompt the client to have a seat and eat his snack. The client did not respond. Several minutes later, the direct care staff was observed putting a snack on the client's plate.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated June 8, 2010, on August 6, 2010, beginning at 9:15 a.m., revealed a program objective which documented, "Upon request, [the</p>	W 249	<p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. QMRP will coordinate and complete additional staff training on the use of the Communication board and the importance of providing continuous active treatment. QMRP/Home Manager will monitor staff activities on an ongoing basis to ensure that interventions and services are provided to the individual whenever there is an opportunity and implemented in accordance to the program. 2. Corrective actions taken for the QMRP for failing to implement program objectives as outlined. Additional training completed on timely implementation and staff 	9.2.10 ongoing

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W 249	<p>Continued From page 8</p> <p>client] will utilize a communication board to express his fundamental wants and needs in response to query for 5 out 6 trials etc....."</p> <p>Interview with the qualified mental retardation professional (QMRP) and house manager on August 6, 2010, at approximately 10:10 a.m., indicated that the client has an communication board. The board was revealed at that time. Further interview revealed that the client should select or request a desired activity. There was no evidence that the staff implemented Client #1's communication goal.</p> <p>2. The facility's staff failed to implement Client #1's IPP.</p> <p>a. Review of Client #1's IPP dated June 8, 2010, on August 6, 2010, beginning at 9:15 a.m., revealed a program objective which documented, "Given physical assistance, [the client] will tolerate cervical active range of motion exercises into flexion, extension, rotation and side-bending, five repetitions each, three days per week for six months.</p> <p>Review of the data collection record on August 6, 2010, at approximately 10:30 a.m., reflected no program data sheets for the month of August 2010. In an interview with the QMRP at 11:15 a.m., he acknowledged that the program has not been implemented.</p> <p>b. Review of Client #1's IPP dated June 8, 2010, on August 6, 2010, beginning at 9:15 a.m., revealed a program objective which stated, "[the client] will walk daily in his neighborhood on 80% of trials recorded per month by June 2011.</p>	W 249	<p>training on program objectives as recommended by the IDT. Program objectives are currently being implemented as recommended.</p>	

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W 249	Continued From page 10 Review of the data collection record on August 6, 2010, at approximately 10:30 a.m., reflected no program data sheets for the month of August 2010. In an interview with the QMRP at 11:15 a.m., he acknowledged that the program has not been implemented.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION 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, the facility failed to ensure that data was collected in the form and required frequency, for one of the three clients in the sample. (Client #1) The finding includes: On August 5, 2010, at 4:05 p.m., and approximately 6:10 p.m., Client #1 was observed smoking a cigarette. Interview with the direct care staff indicated that the client is on a smoking scheduled. He gets eight cigarettes a day. Further interview with the house manager (HM) on August 6, 2010, at approximately 10:00 a.m., indicated that Client #1 has a behavior support plan (BSP) to address his frequency of smoking. Record verification on August 6, 2010, at 10:30 a.m., revealed Client #1's BSP dated October 12, 2009. The BSP identified a challenging behavior of "frequency of smoking". According to the data collection instructions, staff are to record all times	W 252	W252 This Standard will be met as evidenced by: QMRP will coordinate with the Psychologist to conduct additional staff training on the BSP for all persons residing at this location on documentation and data collection as outlined in the accordance with the BSP. The QMRP/Home Manager will conduct weekly review of the documentation and provide feedback and direction to staff as needed to ensure compliance with this standard.	9.2.10 engoua

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W 252	Continued From page 11 when the client is given a cigarette. Further review of the data chart on August 6, 2010, at 11:00 a.m., revealed that the client had no cigarettes on the evening of August 4, 2010, August 5, 2010 or August 6, 2010. Interview with the qualified mental retardation professional (QMRP) and HM indicated that the client smokes every day. Further interview confirmed that the staff failed to document Client #1's frequency of smoking as required by the BSP.	W 252		
W 262	There was no evidence that data had been collected in accordance with the client's BSP, which was necessary for a functional assessment of the client's progress. 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for one of two clients in the sample. (Client #2) The finding includes: Minutes taken at meetings of the facility's HRC for the period June 2009 through January 19, 2010, were reviewed on August 6, 2010, beginning at 12:30 p.m. Review of Client #2's medical chart on August 5, 2010, beginning at 10:45 a.m.	W 262	W262 This Standard will be met as evidenced by: HRC review was conducted in August 2010. HRC has been scheduled for October 2010. QMRP will immediately bring to the attention of HRC Chairperson any program or restrictive techniques recommended for the individuals. HRC will review and approve or make recommendations, prior to the implementation or administration of medications.	8/26/10 mgary

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W 262	Continued From page 12 revealed the following orders for sedation: - On July 7, 2010, Chloral Hydrate 1 gm, one dose, to obtain EKG; - On May 18, 2010, Chloral Hydrate 1 gm, one dose, to obtain EKG; and - On March 22, 2010, Chloral Hydrate 1 gm, one dose, prior to dental examination. Interview with the qualified mental retardation professional (QMRP), and House Manager on August 6, 2010, at 3:00 p.m., revealed that Client #2 received the sedation to address his non-compliance behaviors prior to the medical appointments. Further interview with the director of residential services at approximately 2:10 p.m., indicated that the HRC had not met since January 2010 and the HRC had not reviewed or approved the use of sedation for Client #2.	W 262		
W 325	482.480(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of two clients included in the sample. (Client #1) The finding includes: The facility failed to obtain laboratory studies as	W 325	W325 This Standard will be met as evidenced by: LPN staff will track and monitor lab schedules and recommendations for lab tests. The RN will conduct routine (at least monthly) reviews of all recommended laboratory studies, provide additional training and oversight as needed to ensure ongoing compliance with this standard. The laboratory studies have been completed for person #1. The RN will document in the monthly notes any barriers to obtaining the recommended services.	8/13/10 ongoing

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W 325	Continued From page 13 ordered by the Primary Care Physician (PCP). Review of Client #1's physician's order (PO) from July 1, 2009 to June 1, 2010, on August 5, 2010, beginning at 10:45 a.m., revealed an order for the client to have laboratory studies for HgA1C and Prolactin, every six months. Subsequent review of his medical records revealed the last laboratory studies were completed on July 20, 2009. According to the pharmacy review dated July 18, 2010, it was recommended to obtain the aforementioned laboratory studies. Interview with the licensed practical nurse on August 5, 2010, at 2:04 p.m., confirmed that the studies were not completed as ordered.	W 325		
W 336	There was no documented evidence that HGA1C and Prolactin levels had been performed every six months as ordered by the PCP. 483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's registered nurse (RN) failed to ensure physical examinations were conducted quarterly or on a more frequent basis, for one of the two clients included in the sample. (Client #2) The finding includes: Interview with the facility's Licensed Practical Nurse (LPN) Coordinator on August 5, 2010, at	W 336	W336 This Standard will be met as evidenced by: The quarterly nursing assessment has been completed. The DON will continue to monitor and provide direction and oversight for the RN staff to ensure ongoing compliance with this standard. The RN assigned to this location no longer works with the company.	8.27.10 ongoing

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W 336	Continued From page 14 approximately 10:10 a.m., revealed that the Registered Nurse (RN) should complete quarterly nursing exams. Review of Client #2's medical record on August 5, 2010, beginning at 2:45 p.m., revealed a nursing assessment dated September 10, 2009. Further record review revealed no quarterly nursing review for December 2009. The LPN Coordinator confirmed the missing nursing quarterly reviews for Client #2.	W 336		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, 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. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to maintain in good repair, adaptive feeding equipment as recommended, for one of the two clients included in the sample. (Client #2) The finding includes: Observations on August 5, 2010, at 4:56 p.m., revealed Client #2 having dinner. The client was observed using a scoop plate. The plate was observed melted on the side. Interview with the direct care staff, after Client #2 completed his dinner, revealed that the plate had melted in the dishwasher. Interview with the qualified mental retardation professional (QMRP) on June 8, 2010, at approximately 9:30 a.m.,	W 436	W436 This Standard will be met as evidenced by: The Home Manager has ordered and secured additional scoop plates and will maintain a back up if damage occurs. The QMRP/Home Manager will continue to monitor and track the condition of adaptive equipment used by the people. The QMRP/Home Manager will also document actions taken to address adaptive equipment needs of the people served.	8.11.10 ongoing

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W 436	Continued From page 15 revealed that he was not aware of the client's damaged adaptive feeding equipment. Review of the Client #2's mealtime protocol on August 6, 2010, at approximately 12:30 p.m., revealed that the client required a scoop plate and Dycem mat, to allow the client to become independent during meal. The QMRP indicated he would order a new scoop plate for Client #2. 483.480(b)(2)(iii) MEAL SERVICES	W 436		
W 474	Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each clients food was provided in the prescribed texture, for one of the three clients included in the sample. (Client #1) The finding includes: Cross Refer to W192.1. The facility failed to ensure Client #1's finely chopped diet was prepared and served as prescribed.	W 474	W474 This Standard will be met as evidenced by: Cross refer to W192.1	8-13-10 ongoing

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1 000	<p>INITIAL COMMENTS</p> <p>An licensure survey was conducted from August 5, 2010, through August 6, 2010. A random sample of two residents was selected from a population of four males with various levels of mental retardation and disabilities.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with staff, and the review of clinical and administrative records including incident reports.</p>	1 000		
1 000	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the exterior of the GHMRP was maintained in a safe, orderly, and attractive manner, for four of four residents residing in the facility. (Residents #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>An inspection of the environment was conducted on August 6, 2010, beginning at 11:30 a.m. During the inspection, the surveyor was accompanied by the house manager (HM) and the following concerns were identified:</p> <p>Interior:</p>	1 000	<p>3504.1 Housekeeping</p> <p>This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. The laundry room ceiling has been repaired and painted. 2. The bathroom ceiling vent was cleaned. 3. The faucet in the kitchen was repaired. <p>The Home Manager will conduct weekly environmental checks and forward all requests for repair to the Maintenance department. The QMRP will monitor and supervise to ensure ongoing compliance. The staff will receive additional training on reporting and maintaining home in an orderly attractive manner.</p>	8.13.10 ongoing

Health Regulation Administration

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

TITLE


(X6) DATE
 9/2/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0198	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/08/2010
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I 090	Continued From page 1 1. The laundry room ceiling had chipping and peeling paint. (This deficiency was corrected by the end of the exit conference on the same day). 2. The bathroom ceiling vent was dusty. (This deficiency was corrected by the end of the exit conference on the same day). 3. The faucet in the kitchen sink was dripping. (This deficiency was corrected by the end of the survey). The House Manager confirmed the findings this same day.	I 090		
I 191	3508.8(b) ADMINISTRATIVE SUPPORT Each GHMRP licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts: (b) Liability coverage (premises, personal injury, and products liability in the amount of three hundred thousand dollars (\$ 300,000)) per occurrence; and Professional liability. This Statute is not met as evidenced by: Based on record review and interview, the Group Home for Mentally Retardation Person's(GHMRP) failed to have on file for review, professional liability insurance, for two of the ten consultants. (Psychiatrist and Occupational Therapist) The finding includes: Review of the personnel records on August 8, 2010, at approximately 1:30 p.m., revealed the GHMRP failed to have evidence of professional liability insurance for the Psychiatrist and the	I 191	3508.8 (b) Administrative Support This Statute will be met as evidenced by: The administrative assistant will continue to monitor and track compliance for all consultant files. The Psychiatrist and Occupational Therapist liability insurance has been requested. Continued failure to provide the necessary documents upon request will result in discontinuation of services.	8/31/10 ongoing

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1191	Continued From page 2 Occupational Therapist These deficiencies were acknowledged by the House Manager on August 6, 2010, during the exit conference.	1191		
1204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, a current job description for three of twenty employees (Employee #4, #16 and #19) and one of ten consultants (#7, Occupational Therapist). The finding includes: Review of the personnel files on August, 2010 at approximately 1:00 p.m., revealed the GHMRP failed to provide a current job description for Employee #4, #6 and #19 and the Occupational Therapist. On August 6, 2010 at 4:00 p.m., the House Manager confirmed the findings.	1204	1204 3510 .5 (d) Staff Training This Statute will be met as evidenced by: The HR department tracks CPR/First Aid compliance for all staff. The seven staff have been scheduled to attend the next training. The training records are undergoing further review to obtain the documentation. The Home Manager and QMRP will also monitor staff compliance with CPR/First Aid and schedule staff to attend training prior to expiration.	9.2.10 ongoing
1227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the	1227		

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I 227	Continued From page 3 Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current documentation of training in cardiopulmonary resuscitation (CPR), for seven of the twenty staff (Staff #2, #6, #9 #10, #11 #18, and # 19) and current documentation of training in first aid, for four of the twenty staff (Staff #7, #9, #12, and #14). The finding includes: Review of the personnel and training records on August 6, 2010, beginning at 2:00 p.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for seven of the twenty staff (Staff #2, #6, #9 #10, #11, #18, and # 19) and documentation of training in first aid, for four of the twenty staff (Staff #7, #9, #12, and #14). These deficiencies were acknowledged by the staff members who were present during the exit conference on August 6, 2010.	I 227		
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 technologies; This Statute is not met as evidenced by:	I 229	3510.5 (f) Staff Training This Statute will be met as evidenced by: Refer to responses outlined in W192.	8/13/10 organy

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1 229	Continued From page 4 Based on observations, staff interview and record verification, the Group Home for Persons with Mental Retardation (GHMRP) failed ensure staff received effective training in the area of nutrition, for one of the two residents in the sample. (Resident #1) The finding includes: On August 5, 2010, at 4:05 p.m., direct care staff was observed preparing Resident #1's dinner. The meal consisted of ham, salad, cabbage and macaroni and cheese. The salad, cabbage and macaroni and cheese was cut into bite size pieces and the ham was finely chopped. Interview with the direct care staff, who prepared the client's meal on August 5, 2010, at 6:30 p.m., indicated that Resident #1 was on a finely chopped diet. Review of the resident's current physician orders dated June 2010, revealed a diet order of finely chopped, high fiber 1700 calorie diet. On August 5, 2010, at approximately 8:50 p.m., interview with the license practical nurse revealed that if a resident is ordered a finely chopped diet, they should not receive bite sized piece of food. Review of the facility's in-service training records on August 6, 2010, at approximately 3:00 p.m., revealed that all staff had received training on Resident #1's mealtime protocol on July 15, 2010. However, there was no evidence that training had been effective.	1 229	3519.3 Emergencies This Statute will be met as evidenced by: The emergency phone numbers have been posted by the telephone. The Home Manager also completed staff training to ensure ongoing compliance with this statute.	8/10/10 ongoing
1 372	3519.3 EMERGENCIES Each GHMRP shall post by each telephone emergency numbers, which include at least fire	1 372		

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1372	Continued From page 5 and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons, (GHMRP) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. The finding includes: Observations on August 6, 2010, at 11:30 a.m., revealed there were no emergency phone numbers posted by the telephones in the facility. This deficiency was acknowledged by the house manager on August 6, 2010.	1372		
1374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for one of the two residents included in the sample. (Resident #2)	1374	1374 3519.5 Emergencies This Statute will be met as evidenced by: Reference responses for 1 and 2 to W148 and W153.	8/31/10 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 2553 36TH STREET, SE WASHINGTON, DC 20024		
(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	
1374	<p>Continued From page 6</p> <p>The finding includes:</p> <p>An interview was conducted with the house manager (HM) on August 5, 2010, at 10:10 a.m., during the entrance conference, to ascertain information regarding the facility's incident management system. According to the HM, all incidents should be reported to the administrator, family members and/or guardians and governmental agencies. Further interview revealed Resident #2 had legal guardians that were involved in his habilitation and care. The facility's incident reports and corresponding investigations were reviewed on the same day, beginning at 9:05 a.m. and revealed the following:</p> <p>1. On November 28, 2009, staff discovered an open sore on Resident #2's right elbow. According to the incident report the licensed practical nurse (LPN) initially observed the sore on the resident's elbow on November 21, 2009.</p> <p>Interview with the HM on August 5, 2010, at approximately 12:10 p.m., indicated that he was not sure if the guardian had been notified.</p> <p>2. Reconciliation of the medication administration on August 5, 2010, at approximately 9:50 a.m., revealed an incident report in the medication administration record. The incident report was dated May 14, 2010, for Resident #2. The report indicated that staff discovered a bruise on the resident's lower back, above his waist.</p> <p>Interview with the QMRP on August 5, 2010, at approximately 12:30 p.m., revealed that he was not aware of Resident #2's injury and believed it was an error. Therefore, notifications were not made to resident's guardian, as required by the agency's policy.</p>	1374			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0198	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2553 36TH STREET, SE WASHINGTON, DC 20024		
(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>3519.10 EMERGENCIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure injuries of unknown origin and medication errors were reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for one of the two residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Review of the facility's unusual incident reports (UIR) and investigative reports on August 5, 2010, beginning at 9:05 a.m. revealed an incident report and investigative report for Resident #2 dated June 16, 2010. The incident report indicated that a medication error occurred on June 16, 2010, at 7:00 p.m. According to the incident report the administrator was notified on June 29, 2010 (13 days, later). <p>An interview was conducted with the Qualified Mental Retardation Professional (QMRP) August 5, 2010, at approximately 11:30 a.m., to ascertain</p>	1379	<p>1379</p> <p>3519.10 Emergencies</p> <p>This Statute will be met as evidenced by:</p> <p>Reference response to W153, W154, and W148.</p>	8/31/10 ingonye

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2583 36TH STREET, SE WASHINGTON, DC 20024		
(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	Continued From page 8 Information regarding the facility's incident management system. According to the QMRP, all incidents should be reported to the administrator, immediately. The QMRP confirmed that notifications were not made to the administrator or Department of Health (DOH) timely, as required by the agency's policy. 2. Reconciliation of the medication administration on August 5, 2010, at approximately 9:50 a.m., revealed an incident report in the medication administration record. The incident report was dated May 14, 2010, for Resident #2. The report indicated that staff discovered a bruise on the resident's lower back, above his waist. Interview with the QMRP on August 5, 2010, at approximately 12:30 p.m., revealed that he was not aware of Resident #2's injury and believed it was an error. therefore, notifications were not made to the administrator or Department of Health (DOH), as required by the agency's policy.	1379		
1422	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 Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their individual Habilitation Plan (IHP), for one of the two residents included in the sample. (Resident #1)	1422	3521.3 Habilitation and Training Reference response to W249.	9/2/10 origines

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2553 36TH STREET, SE WASHINGTON, DC 20024		
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I 422	<p>Continued From page 9</p> <p>The findings include:</p> <p>1. On August 5, 2010, at 4:15 p.m., a direct care staff was observed verbally offering Resident #1 snacks. At 4:25 p.m., Resident #1 was observed sitting at the dining room table. After several minutes, the resident stood up and went into the kitchen, looked around and returned to the dining room table. Direct care staff continued to verbally prompt the resident to have a seat and eat his snack. The resident did not respond. Several minutes later, the direct care staff was observed putting a snack on the resident's plate.</p> <p>Review of Resident #1's Individual Program Plan (IPP) dated June 8, 2010, on August 6, 2010, beginning at 9:15 a.m., revealed a program objective which documented, "Upon request, [the resident] will utilize a communication board to express his fundamental wants and needs in response to query for 5 out of 6 trials etc....."</p> <p>Interview with the qualified mental retardation professional (QMRP) and house manager on August 6, 2010, at approximately 10:10 a.m., indicated that the client has a communication board. The board was revealed at that time. Further interview revealed that the resident should select or request a desired activity. There was no evidence that the staff implemented Resident #1's communication goal.</p> <p>2. The facility's staff failed to implement Client #1's IPP.</p> <p>a. Review of Resident #1's IPP dated June 8, 2010, on August 6, 2010, beginning at 9:15 a.m., revealed a program objective which documented, "Given physical assistance, [the resident] will tolerate cervical active range of motion exercises</p>	I 422		

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 2553 36TH STREET, SE WASHINGTON, DC 20024		
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1422	Continued From page 10 into flexion, extension, rotation and side-bending, five repetitions each, three days per week for six months. Review of the data collection record on August 6, 2010, at approximately 10:30 a.m., reflected no program data sheets for the month of August 2010. In an interview with the QMRP at 11:15 a.m., he acknowledged that the program has not been implemented. b. Review of Resident #1's IPP dated June 8, 2010, on August 6, 2010, beginning at 9:15 a.m., revealed a program objective which stated, "[the resident] will walk daily in his neighborhood on 80% of trials recorded per month by June 2011. Review of the data collection record on August 6, 2010, at approximately 10:30 a.m., reflected no program data sheets for the month of August 2010. In an interview with the QMRP at 11:15 a.m., he acknowledged that the program has not been implemented.	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 the Mentally Retarded Persons (GHMRP) 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,	1500	1500 3523.1 Resident's Rights This Statute will be met as evidenced by: Reference response to W262.	8.26.10 ongoing

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1500	<p>Continued From page 11</p> <p>Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the two residents included in the sample. (Resident #2)</p> <p>The findings include:</p> <p>The facility failed to provide evidence that informed consent was obtained from Resident #2's guardian for sedation during a medical appointment as evidenced below:</p> <p>During the entrance conference on August 5, 2010, beginning at 10:10 a.m., house manager (HM) and licensed practical nurse (LPN) indicated that Resident #2 had a court appointed legal guardian to assist the resident in making health care decisions.</p> <p>Review of Resident #2's physician orders (POS) on August 5, 2010, beginning at 2:45 p.m., revealed an order for Chloral Hydrate 1 gm, by mouth, one dose, for a dental appointment.</p> <p>Review of Resident #2's medication administration record (MAR), confirmed that the resident was administered the aforementioned sedation. Further record review revealed signed consent. However the consent form was not checked to indicate whether the guardian consented or not. Interview with the HM and qualified mental retardation professional (QMRP) on August 6, 2010, at approximately 11:30 a.m., indicated that the guardian was usually in agreement with signing consent for the resident's sedation.</p> <p>Review of Resident #2's Psychological Assessment dated September 13, 2009, on</p>	1500		

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 2559 35TH STREET, SE WASHINGTON, DC 20024
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1500	<p>Continued From page 12</p> <p>August 5, 2010, at approximately 12:15 p.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the resident's record failed to provide evidence that informed consent had been obtained for the use of the sedation.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to Resident #2 and/or family members.</p>	1500		