

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

PRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020
--	---

(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>INITIAL COMMENTS</p> <p>A recertification survey was conducted from July 19, 2010, through July 21, 2010. A sampling of four men was selected from a residential population of seven men with various degrees of intellectual and/or developmental disabilities.</p> <p>The findings of the survey were based on observations, interviews staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.</p>	W 000	<p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> <p>W149</p> <p>This Standard will be met as evidenced by:</p>	<p>Received 8/12/10</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 establish and/or implement policies to ensure the health and safety of two of four clients residing included in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>The facility failed to ensure the Department of Health (DOH) was notified timely of significant incidents (or two injuries of unknown origin) in accordance with federal regulations and state law.</p> <p>Cross-refer to W153. Review of the facility's incident reports and corresponding investigative reports on July 19, 2010 beginning approximately 8:28 a.m., revealed no documented evidence of</p>	W 149	<p>a., b., c., The incident Investigations for all of the people has been completed. The Incident Management Coordinator has completed staff training on July 27th and 30th to include but not limited to; Individual Rights, Human Rights, Abuse, Neglect and Exploitation, Incident Management policy, documentation and reporting procedures. The Incident Management Coordinator will conduct routine record reviews to include nursing and physician notes to ensure that all incidents and/or injuries of unknown origin are investigated appropriately.</p>	<p>7/30/10 ongoing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary M...</i>	TITLE <i>NRS</i>	(X6) DATE 8/10/10
---	---------------------	----------------------

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 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: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 149	<p>Continued From page 1 the following:</p> <p>a. Review of Client #2's medical record on July 20, 2010, at approximately 12:42 p.m. revealed a nursing note dated March 29, 2010 written at 8:30 a.m. According to the note, an active treatment staff (ATS) told the Licensed Practical Nurse (LPN) about an abrasion noted to the individual's inner right thigh at 10:45 p.m. Upon assessment, the nurse revealed the abrasion was superficial and that it measured 1.2 x 0.5 cm. The nurse also noted that the area was cleansed according to the aforementioned order. The nursing note revealed the LPN and the facility's Registered Nurse (RN) were the only staff informed of the injury of unknown origin.</p> <p>b. Review of Client #3's medical record on July 20, 2010, at approximately 1:00 p.m. revealed a physician's order dated July 13, 2010, to cleanse the area on the left side of neck with normal saline and to apply A&D ointment twice a day until healed.</p> <p>Review of Client #3's Intra-Agency Communication document dated July 13, 2010, revealed that upon arrival at the day program the client was observed to have a "scrape about 1 cm. long" on the left side of the back of the neck.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 20, 2010, at approximately 1:25 p.m., revealed that it was the facility's policy for the first person who discovered an injury to complete an incident report. There was no documented evidence, however, that the administrator was immediately notified of Client #1 and #3's injury of unknown origin, as required.</p>	W 149	<p>W 149</p> <p>The staff nurse and QMRP must immediately address all Intra-Agency communications and provide immediate follow-up. The QMRP and Home Manager will receive additional training on Incident Management notification process. The Incident Management Coordinator will review all incident reports documentation of notification and conduct follow-up as needed to be sure that the administrator and other notifications are made in accordance to company policy and regulatory requirements.</p> <p>Incident Management Coordinator will trend and track significant occurrences within the incident</p>	7/30/10 organy	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	
(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 149	Continued From page 2 Review of the facility's incident management policy (IMP) on July 21, 2010 at approximately 4:00 p.m., revealed that incidents were categorized into both reportable and serious reportable incidents. According to the policy "any injury, regardless of severity, of unknown origin shall be considered a serious physical injury." According to the policy, "it is the responsibility of any staff member who witnesses, discovers or is informed of an incident to complete an incident report." Continued review of the policy revealed "upon occurrence of a serious reportable incident, other than a death", staff shall call the immediate supervisor or manager on duty and the Department of Health/Health Regulations Administration. Review of the facility's incident reports, however, revealed that the facility had not consistently notified the State agency of incidents, as required.	W 149	W149 - Continued... Management process and identify systemic practices and conduct at least quarterly safety reviews to address indicators. Administrator and/or designee will review and sign all investigative reports in accordance to company policy.	7/30/10 engany
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. This STANDARD is not met as evidenced by: Based on observation, interview and review of incident reports and investigations, the facility failed to ensure that all allegations of neglect or abuse, as well as injuries of unknown origin were reported immediately to the administrator and/or the Department of Health, Health Regulation and	W 153	W153 This Standard will be met as evidenced by: Cross reference response to W149.	7/30/10 engany

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

PRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	
(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 153	<p>Continued From page 3</p> <p>Licensing Administration (HRLA) timely, for two of the four clients residing in the facility. (Clients #2 and #3)</p> <p>The findings include:</p> <p>Review of the facility's incident reports and corresponding investigative reports on July 19, 2010 beginning approximately 8:28 a.m., revealed no documented evidence of the following:</p> <p>1. Review of Client #2's medical record on July 20, 2010, at approximately 12:42 p.m. revealed a physician's order dated March 29, 2010. Continued review of the order revealed Client #1 had been prescribed the following: "cleanse abrasion to right inner thigh with (normal saline solution) NSS and pat dry, apply neosporin BID, leave open to air until healed." Further review of the client's medical record revealed a nursing note dated March 29, 2010 written at 8:30 a.m. According to the note, an active treatment staff (ATS) told the Licensed Practical Nurse (LPN) about an abrasion noted to the individual's inner right thigh at 10:45 p.m. Upon assessment, the nurse revealed the abrasion was superficial and that it measured 1.2 x 0.5 cm. The nurse also noted that the area was cleansed according to the aforementioned order. The nursing note revealed the LPN and the facility's Registered Nurse (RN) were the only staff informed of the injury of unknown origin.</p> <p>Interview with the Qualified Mental Retardation Professional on July 20, 2010, at approximately 1:05 p.m., revealed that it was the facility's policy for the first person who discovered an injury to complete an incident report. There was no</p>	W 153		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	
(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 153	Continued From page 4 documented evidence, however, that the administrator was immediately notified of Client #1's injury of unknown origin, as required. 2. Client #3 was observed on July 19, 2010 at approximately 8:15 a.m. to have an abrasion that appeared to be healing on the left side of his neck. Review of Client #3's Medication Administration Record (MAR) record on July 19, 2010, at approximately 8:10 a.m. revealed an order to cleanse the area on the left side of the neck with normal saline and to apply A&D ointment twice a day until healed. Review of Client #3's medical record on July 20, 2010, at approximately 1:00 p.m. revealed a physician's order dated July 13, 2010, to cleanse the area on the left side of neck with normal saline and to apply A&D ointment twice a day until healed. Review of Client #3's Intra-Agency Communication document dated July 13, 2010, revealed that upon arrival at the day program the client was observed to have a "scrape about 1 cm. long" on the left side of the back of the neck. Interview with the Qualified Mental Retardation Professional (QMRP) on July 20, 2010, at approximately 1:25 p.m., revealed that it was the facility's policy for the first person who discovered an injury to complete an incident report. There was no documented evidence, however, that the administrator was immediately notified of Client #3's injury of unknown origin, as required.	W 153		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS	W 156	W156 This Standard will be met as evidenced by: Reference response to W149.	7/30/10 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 156	Continued From page 5 The results of all investigations must be reported to the administrator or designated representative 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 ensure required investigations were reviewed by the administrator or designee within five working days, for one of the four clients included in the sample. (Client #3) The finding includes: Interview with the Facility's Coordinator (FC) and review of the facility's incident reports, including the available corresponding investigative reports, on July 19, 2010, beginning at approximately 8:28 a.m., revealed an incident involving Client #3 dated May 9, 2010. According to the report, the staff noticed the resident's right knee with redness and it was observed to be swollen. Review of the corresponding internal investigative summary revealed the investigation was conducted and completed by the Incident Management Coordinator (IMC) on May 15, 2010. Further interview with the FC revealed the results of all investigations are reported to and reviewed by the administrator. At the time of the survey, there was no documented evidence that the results of the aforementioned investigation were reported to the facility's administrator within five working days as required.	W 156	W189 This Standard will be met as evidenced by: Incident Management Coordinator completed additional training. Incident Management Coordinator will conduct follow-up and routine record reviews to ensure that staff perform their duties effectively and efficiently. Managers and Supervisors assigned to the home will also monitor staff performance and take necessary corrective actions when needed to include but not limited to; training, disciplinary action up to and including termination of employment. DRS and DON will also conduct routine file audits and observations to further ensure compliance with this standard.	7/30/10 ongoing	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the	W 189	Also cross reference response to W149.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 6 employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: Cross Refer to W153 and W156. The facility failed to ensure that the Incident Management Coordinator (IMC), Licensed Practical Nurse (LPN) and Active Treatment Specialist Staff (ATS) had received effective training on their incident management policy to ensure clients observed with injuries of unknown origin were reported and documented. Review of the facility's training on July 21, 2010, at approximately 2:00 p.m. revealed an "Incident Management in-service Training held on April 30, 2010. At the time of the survey, the facility failed to ensure the Incident Management Training was effective.	W 189		
W 242	483.440(c)(8)(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.	W 242	W242 This Standard will be met as evidenced by: The OT has developed program plans for client #1 and #3 to address the training needs to improve oral hygiene. QMRP has updated the individual's program plan and conducting further review of all individual's hygiene needs. Additional programs will be added as needed to improve oral health and increase independence. QMRP conducted staff training on program objectives and maintaining good oral hygiene practices for all of the people served.	8/6/10 ongang

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

PRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020	
(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 242	<p>Continued From page 7</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 individual program plan (IPP) included training in activities of dental hygiene, for two of the four clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. Interview with the Qualified Mental Retardation Professional (QMRP) on July 20, 2010, at approximately 3:18 p.m., revealed Client #1 brushes his teeth after each meal.</p> <p>Review of Client #1's medical record on July 20, 2010, at approximately 3:30 p.m., revealed a dental consultation dated July 20, 2009. Further review of the dental consultation revealed the client had large deposits of plaque and calculus present on his teeth. The dentist recommended to assist the client with "brushing two (2) times daily. Another dental consultation dated June 15, 2010 revealed Client #1's needed scaling.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated January 11, 2010 revealed no evidence of a training program to address the client's poor oral hygiene.</p> <p>During the interview with the QMRP on July 20, 2010 at approximately 4:15 p.m., it was acknowledged Client #1 did not have a training program to address his poor oral hygiene.</p> <p>There was no evidence the facility ensured the client's IPP included training in activities of dental hygiene.</p>	W 242		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 242	Continued From page 8 2. On July 21, 2010, at approximately 7:50 a.m., during medication administration, Client #3 was observed with brown stains on his teeth. Review of Client #3's medical record on July 20, 2010, at approximately 11:35 a.m., revealed a dental consultation dated May 24, 2010, that recommended the client "brush teeth two (2) times a day. Continued review of the client's record revealed some signs of gingivitis and adult prophylaxis needed. Review of Client #3's Individual Program Plan (IPP) dated July 2010 at approximately 11:50 a.m. revealed no evidence of a training program to address the client's poor oral hygiene. During an interview with the LPN on July 21, 2010, at approximately 11:55 a.m., it was acknowledged Client #3 did not have a training program to address his poor dental hygiene. There was no evidence the facility ensured the client's IPP included training in activities of dental hygiene.	W 242	W249 This Standard will be met as evidenced by: 1. QMRP and Home Manager conducted follow-up review of all program objectives to ensure implementation program goals as outlined in the IPP. The QMRP will coordinate additional training on ROM programs if needed. Physical Therapy consultant has been requested to provide greater oversight and monitoring of all recommended program objectives and maintain communications with the QMRP. Both will address barriers to program implementation, evaluate progress and make changes as needed.	8/9/10 ongoing
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by:	W 249		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE: 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>Continued From page 9</p> <p>Based on observation, interview and record review, the facility failed to ensure each client received continuous active treatment services, for one of the four clients (Client #1) included in the sample.</p> <p>The findings include:</p> <p>1. The facility failed to ensure Client #1's range of motion (ROM) exercises program objective was implemented in accordance with the IDT recommendations as evidenced below:</p> <p>Interview with Facilities Coordinator (FC) and review of the habilitation record on July 20, 2010, at 11:34 a.m. revealed Client #1 had a physical therapy assessment dated January 7, 2010. Review of the physical therapy assessment revealed the therapist recommended the following program objectives: 1) Given physical assistance the client will tolerate ROM exercises five (5) trial three (3) days per week for six (6) consecutive months and 2) Given physical assistance the client will tolerate lower extremity weight bearing for ten (10) seconds 3/3 trials for six (6) consecutive months.</p> <p>Further interview with the FC and review of Client #1's Individual Program Plan, (IPP) revealed the program objective for weight bearing had been implemented. At the time of the survey, however, there was no documented evidence that Client #1's objective to tolerate ROM exercises was implemented.</p> <p>2. The facility failed to ensure Client #1's reading activity program objective was implemented in accordance with the IDT recommendations as evidenced below:</p>	W 249	<p>2. QMRP will provide greater oversight of all program objectives and goals. QMRP will highlight the correct days of program implementation to ensure clearer direction for staff. QMRP and Home Manager will review program documentation weekly and provide appropriate follow-up as needed.</p>	8/1/10 ongoing	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE: 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	Continued From page 10 Interview with Qualified Mental Retardation Professional (QMRP) and review of the habilitation record on July 20, 2010, at 10:50 a.m. revealed Client #1 had a social work assessment dated January 11, 2010. Review of the social work assessment revealed the social worker recommended a program objective to participate three (3) times per week in an interactive reading activity (sing along CD or interactive book) that shows cause and effect for ten (10) minutes with gestural assistance for six (6) consecutive months by July 2010. Continued interview with the QMRP and review of Client #1's individual Program Plan (IPP) dated January 11 2010, revealed the program was implemented three times per month. Review of the program data revealed the direct care staff had been instructed to implement the program three (3) times per month instead of three (3) times per week. During an interview with the QMRP on July 20, 2010, at approximately 11:15 a.m., it was acknowledged that Client #1's program objective to participate in a reading activity was implemented three (3) times per month instead of three (3) times per week. At the time of the survey, the facility failed to ensure the program objective for Client #1 to participate in a reading activity was implemented three (3) times a week as recommended.	W 249			
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels.	W 391	W391 This Standard will be met as evidenced by:		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 07/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 391	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to remove medications that had missing labels from its use, for one of the four clients in the sample. (Client #2) The finding includes: On July 19, 2010, at approximately 6:30 a.m., the Licensed Practical Nurse (LPN) was observed to place a bottle of liquid Tegretol with a missing label on the dining room table. Interview with the LPN at approximately 6:40 a.m. acknowledged that the bottle of liquid Tegretol had a missing label and belonged to Client #2. Further interview revealed the pharmacist would be notified and the bottle of Tegretol would be replaced. There was no evidence that the facility removed all medications that had a missing labels from use.	W 391	W 391 The DON will explore with the pharmacist to determine if medications can be dispensed with plastic cover over the labels to prevent peeling. The refrigerator temperature and condensation continues to be monitored carefully. RN's will continue to monitor the medication labels to ensure ongoing compliance with this standard.	8/10/10 orgoww	

PRINTED: 07/30/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020
--	---

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

1090	<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 the Mentally Retarded Persons (GHMRP) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner.</p> <p>The findings include:</p> <p>Observation and interview with the facility's house manager (HM) on July 19, 2010, beginning at 11:30 a.m. revealed the following:</p> <p>Exterior:</p> <ol style="list-style-type: none"> 1. The front entrance gate to the property is broken and will not close properly posing as a possible safety/security issue. 2. The front porch roof gutters had evidence of leaves, small branches and spider webs. <p>Interior:</p> <ol style="list-style-type: none"> 1. The rear entrance floor near the door has several broken tiles that could potentially become a tripping hazard. 2. In the laundry room there are water stained ceiling tiles. 3. There were several minor deficiencies 	1090	<p><i>3504.1 Housekeeping</i></p> <p>This Statute will be met as evidenced by:</p> <p>1-3 have been addressed and necessary repairs completed. The Home Manager continues to conduct weekly home inspections as well as a comprehensive monthly review of the environment. The Home Manager will forward a request for repairs to the Maintenance department whenever needed. The Maintenance department will continue to complete and require signature of verification that the requested repairs have been completed.</p>	<p><i>7/26/10 ongoing</i></p>
------	--	------	--	-------------------------------

Health Regulation Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

Nancy Branch

TITLE
NBS

(X6) DATE
8/10/10

PRINTED: 07/30/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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
1090	Continued From page 1 throughout the facility such as light bulbs out and dust on several ceiling and wall vents. However the deficiencies were eliminated prior to the survey team leaving the facility. All of the deficiencies were acknowledge by the House Manager(HM) at the conclusion of the environmental inspection.	1090		
1206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on personnel record review and staff interview, the group home for the mentally retarded person's (GHMRP) failed to ensure a current health screening for one of twenty-two employees (#11) and one of eight consultants, the psychologist. The finding includes: During a record review and interview with the Qualified Mental Retardation Professional (QMRP), on July 19, 2010, at approximately 1:30 p.m., revealed direct care staff (#11) and the psychologist did not have a current health screening certificate on file. These findings were acknowledged by the QMRP at the time of the record review.	1206	3509.6 This Statute will be met as evidenced by: Staff #11 had a current health certificate at the time of the review. A current health certificate has been requested from the psychologist. The Administrative assistance will continue monitor and track all required information and request in advance of expiration date. Anyone failing to comply will be removed from the assignment in the home until necessary documents have been obtained.	8.9.10 ongoing

PRINTED: 07/30/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 370	3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to consistently document the reporting of incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (§2 DCMR Chapter 35 Section 3519.10). The finding includes: Review of unusual incident reports was conducted on July 19, 2010, at approximately 9:25 a.m. Continued review of the incident reports revealed an investigative report dated February 5, 2010. According to the investigative report, Resident #7 was involved in an incident on January 28, 2010. Interview with the Facilities Coordinator (FC) on July 19, 2010 at approximately 3:00 p.m. revealed there was no evidence of an incident report. Further review of the investigative report revealed that Resident #7 had experienced three episodes of vomiting while he was at his day program. The report also revealed that the resident was escorted to a local emergency room, at which time he was admitted to the hospital. At the time of the survey, there was no documented evidence that this incident had been reported to governmental agencies as required.	I 370		
I 432	3521.7(c) HABILITATION AND TRAINING	I 432		

Health Regulation Administration
STATE FORM

6699

F7X911

If continuation sheet 3 of 6

PRINTED: 07/30/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 432	<p>Continued From page 3</p> <p>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:</p> <p>(c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care);</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene, for two of the four residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>Interview with the Qualified Mental Retardation Profession (QMRP) on July 20, 2010, at approximately 3:18 p.m., revealed Resident #1 brushes his teeth after each meal.</p> <p>Review of Resident #1's medical record on July 20, 2010 at approximately 3:30 p.m., revealed a dental consultation dated July 20, 2009. Further review of the dental consultation revealed the client had large deposits of plaque and calculus present on his teeth. The dentist recommended to assist the resident with "brushing two (2) times daily. Another dental consultation dated June 15, 2010 revealed Resident #1's needed scaling.</p> <p>Review of Resident #1's Individual Program Plan (IPP) dated January 11, 2010 revealed no evidence of a training program to address the client's poor oral hygiene.</p> <p>During the interview with the QMRP on July 20, 2010 at approximately 4:15 a.m., it was acknowledged Resident #1 did not have a</p>	I 432	<p>3521.7 ©</p> <p>This Statute will be met as evidenced by:</p> <p>Reference response to W242.</p>	8/6/10 ongary

PRINTED: 07/30/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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
1432	Continued From page 4 training program to address his poor oral hygiene. There was no evidence the facility ensured the resident's IPP included training in activities of dental hygiene. 2. On July 21, 2010, at approximately 7:50 a.m., during medication administration Resident #3 was observed with brown stains on his teeth. Review of Resident #3's medical record on July 20, 2010 at approximately 11:35 a.m., revealed a dental consultation dated May 24, 2010, that recommended the resident "brush teeth two (2) times a day. Continued review of the client's record revealed some signs of gingivitis and adult prophylaxis needed. Review of Resident #3's Individual Program Plan (IPP) dated July 2010 at approximately 11:50 a.m. revealed no evidence of a training program to address the client's poor oral hygiene. During an interview with the LPN on July 21, 2010 at approximately 11:55 a.m., it was acknowledged Resident #3 did not have a training program to address his poor dental hygiene. There was no evidence the facility ensured the resident's IPP included training in activities of dental hygiene.	1432		
1484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.	1484	3522.11 This Statute will be met as evidenced by: Reference response to W391.	8/10/10 ongoing

PRINTED: 07/30/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020		
(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 484	Continued From page 5 This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) nursing staff failed to remove from use, medications that had a missing label, for one of four residents in the sample. (Resident #2 The finding includes: On July 19, 2010, at approximately 6:30 a.m., the Licensed Practical Nurse (LPN) was observed to place a bottle of liquid Tegretol with a missing label on the dining room table. Interview with the LPN at approximately 6:40 a.m. acknowledged that the bottle of liquid Tegretol had a missing label and belonged to Resident #2. Further interview revealed the pharmacist would be notified and the medication would be replaced. There was no evidence that the facility removed all medications that had a missing labels from use.	I 484		