

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 12/04/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019
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(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
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(W 000)	<p>INITIAL COMMENTS</p> <p>A revisit was conducted on December 3, 2009, through December 4, 2009, to verify the facility's compliance with condition level deficiencies cited during a complaint investigation dated October 16, 2009. A random sample of three clients was selected from a residential population of six females with various disabilities. The findings of the survey were based on observations in the home, interviews with direct care and nursing staff, as well as a review of the clinical, administrative, and habilitative records; including a review of the unusual incident reports.</p> <p>The revisit resulted in a determination that although progress had been made in correcting previously cited deficiencies, continuing condition-level deficiencies remained that preclude finding the facility in compliance with the Conditions of Participation in Governing Body and Health Care Services.</p> <p>On December 3, 2009, at approximately 5:40 p.m., the facility's Acting Qualified Mental Retardation Professional (AQMRP), Registered Nurse Supervisor, and Licensed Practical Nurse were notified that a client was observed coughing multiple times and spitting out large amounts of liquid during the evening meal. Based on further observation, interview and record verification, it was revealed that the facility's staff failed to effectively implement the client's mealtime protocol and the observed client was at risk for aspiration. The facility was informed that the observed actions posed likely harm to the client.</p> <p>On December 3, 2009, at approximately 8:40 p.m., the facility's AQMRP implemented and submitted to the State Agency (SA) a plan of</p>	(W 000)	<p>12/21/09</p> <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>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE 12/21/09

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.

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

09G123

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

R

12/04/2009

NAME OF PROVIDER OR SUPPLIER

INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

431 68RD STREET, SE  
WASHINGTON, DC 20019

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
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PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

(W 000)

Continued From page 1  
correction to address the identified concern as  
detailed below:

1. All staff and nurses present during the  
observed evening meal were trained on Client  
#2's mealtime protocol. (Completed December 3,  
2009)
2. The overnight staff will receive training on  
Client #2's mealtime protocol. (Completed  
December 5, 2009)
3. The morning staff will receive training on Client  
#2's mealtime protocol. (Completed December 4,  
2009)
4. In addition, all staff in the home will receive  
follow-up training on mealtime protocols, adaptive  
feeding equipment, and the use of adaptive  
feeding equipment on an ongoing or as needed  
basis.
5. Nursing and management will monitor  
mealtimes to ensure that staff adhere to the  
protocols as outlined on a monthly basis.

(W 000)

(W 102)

483.410 GOVERNING BODY AND  
MANAGEMENT

The facility must ensure that specific governing  
body and management requirements are met.

This CONDITION is not met as evidenced by:  
Based on observation, interview, and record  
review, the facility's governing body failed to  
maintain general operating direction over the  
facility. (See W104 and W331)

(W 102)

W102

This Condition will be met as  
evidenced by:  
References response to W104 and  
W331 and  
W318.

12-20-09  
original

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{W 102}

Continued From page 2

{W 102}

{W 104}

The effects of these systemic practices resulted in the governing body's failure to adequately manage the facility in a manner that would ensure each client's health and safety. [See also W318] 483.410(a)(1) GOVERNING BODY

{W 104}

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility's governing body failed to exercise general operating direction over the facility as evidenced by deficiencies cited below and those cited throughout this report for four of six clients residing in the facility. (Clients #2, #3, #4, and #6)

The findings include:  
On November 18, 2009, the facility submitted a Plan of Correction (POC) to the Department of Health to address deficiencies cited as a result of the October 16, 2009 Investigation/survey. On October 16, 2009, the facility was cited for failing to ensure the health and safety of the clients residing in the facility. According to the POC dated November 18, 2009, the facility documented that it would ensure that direct care and nursing staff received additional training on implementing mealtime protocols.

1. Cross-Refer to W192.1. The governing body failed to ensure each employee providing direct care and nursing services were competently trained to implement Client #2's mealtime

- W104**  
This Standard will be met as evidenced by:
1. Cross-reference response to W192.1.
  2. Cross reference response to W192.2
  3. Cross reference response to W192.3
  4. Cross reference responses to WW368
  5. Cross reference responses to W369.

12/20/09  
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{W 104}	Continued From page 3 protocol.  2. Cross-Refer to W192.2. The governing body failed to ensure that each licensed staff had received effective training on procedures to properly implement/document Client #3's fluid restrictions as ordered by the Primary Care Physician (PCP).  3. Cross-Refer to W192.3. The facility's nursing staff failed to utilize standard nursing practices by ensuring universal precautions were implemented while administering Client #4's injections.  3. Cross refer to W331. The governing body failed to ensure nursing services in accordance with each client's needs, for three of the six clients residing in the facility.  4. Cross-refer to W 368. The governing body failed to ensure that all medications were administered in accordance with physician's orders, for two of the six clients residing in the facility.  5. Cross-refer to W 369. The governing body failed to ensure that all medications were administered without error, for one of the six clients residing in the facility.	{W 104}		
{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.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure each employee	{W 192}	W192  This Standard will be met as evidenced by:  1. All staff received retraining on mealtime protocols and will be observed to ensure that they have acquired competency. Staff who fail to adhere to the mealtime protocol after training/retraining will be disciplined.	12/20/09 Ongoing

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{W 192}	<p>Continued From page 4</p> <p>providing direct care and nursing services were competently trained to implement mealtime protocols and calculate fluid restrictions, for three of six clients residing in the facility. (Clients #2, #3, and #4) This failure posed likely harm to the clients' health and safety. Additionally, the facility failed to ensure nursing staff were effectively trained to administer injections while adhering to universal precautions and standard nursing practices, for one of six clients residing in the facility. (Client #4)</p> <p>The findings include:</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC, the facility documented that staff would receive additional training on ensuring consistency with mealtime protocols in accordance with the Physician's Orders. Additionally, the POC documented that nurses would accurately implement/document client's fluid restriction as prescribed.</p> <p>1. The direct care and nursing staff failed to demonstrate competency in implementing Client #2's mealtime protocol as detailed below:</p> <p>Observations during dinner on December 3, 2009, beginning at 5:45 p.m., revealed Client #2 was being assisted by Staff #1 to eat her meal. The meal consisted of pureed pork chops, string beans, zucchini, and cranberry grape juice. At 5:46 p.m., the House Manager (HM) was observed to assist Client #2 with drinking her cranberry juice using hand over hand assistance. When the HM looked away momentarily, Client</p>	{W 192}	<p>W192, Continued...</p> <p>The Home Manager and assigned LPN will conduct random meal observations at least four times monthly. These observations will continue to be documented on the "Meal Observation form." The assigned RN Supervisor will also conduct random meal observations to ensure ongoing compliance. If deficiencies are noted during the meal observations immediate retraining will be implemented and documented on the observation form. If deficiencies are noted during the meal observations immediate retraining will be completed by the LPN and/or Manager on shift. This information will documented directly onto the meal observation form.</p>	12/20/09 ongoing	

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{W 192}	<p>Continued From page 5</p> <p>#2 independently began to drink and was observed to take a large gulp of four (4) ounces of juice. Client #2 immediately started to cough multiple times as a large amount of liquid spilled from both sides of her mouth. Prior to the client coughing, the surveyor observed staff taking the spout lid off of the client's cup while assisting the client with drinking her juice. The nurse immediately intervened by telling the staff to stop feeding until Client #2 cleared her throat. Once the client stopped coughing, the nurse went to retrieve more cranberry juice. The nurse then gave the staff member the cup of juice (without the spout lid) and that staff member resumed feeding the client and assisting her with drinking without the spout lid on the cup. At that time, the surveyor immediately intervened by informing the Acting QMRP/Assistant Director of Residential Services, who was on site, that the client was being fed juice without the benefit of the spout lid. The AQMRP intervened by stopping staff from continuing to allow Client #2 to drink without the spout lid and placed the lid onto the cup.</p> <p>Interview with Staff #2 at 5:57 p.m., revealed that Client #2 did not use the spout lid and the only reason the spout lid was initially on the cup was because the cup of juice was being refrigerated. When interviewed regarding what the spout lid was used for, the staff revealed that the spout lid was necessary to decrease the flow of fluid while drinking. At approximately 6:00 p.m., interview with the HM revealed that the spout cup was discontinued but, there was no documented evidence to support the HM's statement.</p> <p>Review of Client #2's mealtime protocol dated October 2, 2009, on December 3, 2009, at approximately 5:50 p.m., (which was noted to be</p>	{W 192}			

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{W 192}	<p>Continued From page 6</p> <p>on the table during the dinner meal), indicated that Client #2 was at risk for aspiration and identified special feeding equipment (open handled mug with spout lid). Interview with the AQMRP/Director of Residential Services on December 4, 2009, at approximately 10:30 a.m., revealed that staff was trained on Client #2's mealtime protocol. Record review on December 4, 2009, at approximate 2:45 p.m., confirmed that staff was trained on Client #2's mealtime protocol on November 30, 2009. There was no evidence that training had been effective.</p> <p>It should be noted that this is a repeat deficiency.</p> <p>2. Cross-refer to W 331.2. The facility's nursing services failed to ensure that each licensed staff had received effective training on procedures to properly implement/document Client #3's fluid restriction as ordered by the Primary Care Physician (PCP).</p> <p>On December 3, 2009, at approximately 6:15 p.m., Client #3 was observed to drink eight (8) ounces of beverage during the dinner meal. Review of Client #3's mealtime protocol dated September 30, 2009, after dinner revealed the client was prescribed a 1500cc/day fluid restriction.</p> <p>Review of the December 2009 Fluid Intake Monitoring Sheets (FIMS) on December 4, 2009, at approximately 2:30 p.m., revealed the facility's nursing staff documented Client #3's fluid intake during the month of November 2009 as detailed below:</p> <p>a. Client #3 received less than 1500 cc fluids on November 2, 2009 (1270 cc), November 14, 2009</p>	{W 192}	<p>W192 Continued...</p> <p>2. Cross reference response to W331.2</p> <p>3. The Director of Residential Services and DON reviewed the facility policy on universal precautions. All staff are expected to adhere to the policy as written, i.e., gloves will be worn when administering injections and topical medications. The RN Supervisor will conduct random medication administration observations and provide direction and training, immediately and/or as needed to LPN staff. Verification of the training will be indicated on the medication administration observation form.</p>	12.7.09 ongoing

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(W 192)	<p>Continued From page 7 (1200 cc), November 17, 2009 (1440 cc), November 20, 2009 (1240 cc), and November 22, 2009 (1470 cc).</p> <p>b. Client #3's FIMS documented she received over the 1500 cc fluid allotment for twenty-four (24) days. For example:</p> <ul style="list-style-type: none"> <li>- On November 5, 2009, the client received a total of 1590 cc of fluids.</li> <li>- On November 13, 15, and 16, 2009, the client received a total of 1680 cc's of fluids.</li> <li>- On November 18, 19, 20, 23, 24, 25, 26, and 27, 2009, the client received a total of 1550 cc's of fluids daily.</li> </ul> <p>Continued record review of Client #3's Physician's Orders and interview with the facility's Registered Nurse (RN) and Acting QMRP/Assistant Director of Residential Services on the same day at approximately 3:20 p.m., verified that Client #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Client #3's FIMS revealed that staff inaccurately documented a total of 1600 cc's daily for the entire month of November 2009. Further interview with the RN and Acting QMRP acknowledged the fluid intake monitoring sheets were inaccurate for November 2009 and the facility was not adhering to the 1500 cc of fluid daily as prescribed. Additional interview with the Acting QMRP revealed that all direct care and nursing staff had received training on fluid restrictions documentation.</p> <p>Review of the in-service training records on December 4, 2009, at approximately 4:25 p.m., revealed staff were trained on fluid</p>	(W 192)			

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(W 192)	<p>Continued From page 8</p> <p>Intake/restrictions documentation on November 20, 2009. There was no evidence that training had been effective.</p> <p>It should be noted that this is a repeat deficiency.</p> <p>3. The facility's nursing staff failed to utilize standard nursing practices by ensuring universal precautions were implemented while administering Client #4's injections.</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated November 18, 2009, the facility documented that additional staff training had been completed November 24, 2009 on infection control and maintaining sanitary conditions including the use of gloves and hand washing at all times.</p> <p>Observation on December 4, 2009, at 8:18 a.m., revealed the Registered Nurse (RN) injected Client #4 with eight units of Novolog without wearing gloves. Further observation revealed the RN wiped the punctured area with an alcohol pad.</p> <p>Interview with the RN on December 4, 2009, at approximately 10:00 a.m., revealed that "there was no need to wear gloves because body fluids are not exchanged." Review of the medication administration policy/procedures on December 4, 2009, at approximately 10:45 a.m., revealed that gloves were required when administering external medications.</p>	(W 192)		
(W 318)	<p>483.460 HEALTH CARE SERVICES</p> <p>The facility must ensure that specific health care services requirements are met.</p>	(W 318)		

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(W 318)	Continued From page 9  This <b>CONDITION</b> is not met as evidenced by: Based on observation, interview, and record verification, the facility failed to ensure nursing services established systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; failed to ensure that all drugs were administered in accordance with the physician's orders [Refer to W368]; failed to ensure that all medications were administered without error [Refer to W369] and failed to ensure that nurses were trained to competently provide nursing services [Refer to W192].	(W 318)		
(W 331)	483.460(c) <b>NURSING SERVICES</b>  The facility must provide clients with nursing services in accordance with their needs.  This <b>STANDARD</b> is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with each client's needs, for four of the six clients residing in the facility. (Clients #2, #3, #4, and #6)  The findings include:  On November 16, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated	(W 331)	W331  This Standard will be met as evidenced by:  1. Cross reference response to W192. 2. Cross reference response to W192.2 3. Cross reference response to W192.3 4. Cross reference response to W368. 5. Cross reference response to W369.	12/20/09 ongoing

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{W 318}	Continued From page 9  This <b>CONDITION</b> is not met as evidenced by: Based on observation, interview, and record verification, the facility failed to ensure nursing services established systems to provide health care monitoring and identify services in accordance with clients' needs [Refer to W331]; failed to ensure that all drugs were administered in accordance with the physician's orders [Refer to W355]; failed to ensure that all medications were administered without error [Refer to W359] and failed to ensure that nurses were trained to competently provide nursing services [Refer to W192].  The effects of these systemic practices resulted in the facility's failure to provide health care services.	{W 318}	W318  This Condition will be met as evidenced by:  Reference responses to W192, W331, W368, and W369. The DON in coordination with the RN's will ensure that that nurses provide health care monitoring and identify services in accordance with the people's needs and facility policy. The DON will conduct ongoing monitoring reviews to ensure that drugs are administered without error and that nurses receive training and demonstrate necessary competencies in accordance nursing standards.	12-20-09 JN90176
{W 331}	483.450(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.  This <b>STANDARD</b> is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with each client's needs, for four of the six clients residing in the facility. (Clients #2, #3, #4, and #6)  The findings include:  On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated	{W 331}		

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 331}	Continued From page 10 November 18, 2009, the facility documented that nurses accurately implement/document client's fluid restriction as prescribed.  1. Cross-refer to W192.1 The nursing staff failed to demonstrate competency in implementing Client #2's mealtime protocol.  2. Cross-refer to W192.2. The facility's nursing services failed to properly implement/document Client #3's fluid restriction as ordered by the Primary Care Physician (PCP). 3. Cross-fer to W192.3. The facility's nursing staff failed to utilize standard nursing practices by ensuring universal precautions were implemented while administering Client #4's injections. 4. Cross-refer to W368. The facility's nursing services failed to ensure that Clients #4 and #6's medications were administered in accordance with physician's orders. 4. Cross-refer to W369. The facility failed to ensure that all medications were administered without error.	{W 331}			
W 368	483.460(k)(1) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with physician's orders, for two of the six clients residing in the facility. (Client #4 and #6)  The findings include:	W 368			

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W 368	<p>Continued From page 11</p> <p>1. The facility's medication nurse failed to ensure that Client #4's medication was administered as prescribed.</p> <p>Observation of the medication administration on December 4, 2009, at 8:18 a.m., revealed Client #4 was administered Synthroid. Review of the Medication Administration Record (MAR) and current Physician's Orders dated December 2009, after the medication administration at approximately 9:30 a.m., revealed the aforementioned medication should have been administered between 5:00 a.m. and 7:00 a.m.</p> <p>Interview with the License Practical Nurse (LPN) on December 4, 2009, at approximately 10:00 a.m., revealed Client #4 should have received the Synthroid medication no later than 7:00 a.m.</p> <p>2. The facility's medication nurse failed to ensure that Client #6's Nitroglycerin patch was administered as prescribed.</p> <p>On December 4, 2009, at approximately 6:50 a.m., the LPN was observed to sign and date the Nitroglycerin patch. The LPN was then observed to apply Client #6's Nitroglycerin patch to her back. Review of Client #6's December 2009 MAR and December 2008 Physician's Orders after the medication administration at approximately 9:35 a.m., revealed the Nitroglycerin patch should have been applied to Client #6's chest wall.</p> <p>Interview with the LPN on the same day at approximately 10:00 a.m., revealed that Client #6 would removed the Nitroglycerin patch when placed on her chest and therefore, the patch was</p>	W 368	<p>W368</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>The medication nurse will administer medications as prescribed by the primary care physician. If the needs of an individual changes, the nurse will immediately inform the primary care physician for direction and follow-up. All new or modified orders will be documented and implemented as ordered by the PCP.</li> <li>See response to #1, W368.1. The nursing staff have been retrained in protocols for contacting the primary care physician. The primary care physician has written a new order to reflect the application of the patch for the person designated as "client #4".</li> </ol>	<p>12-17-09 omgping</p> <p>↓</p>	

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W 368	Continued From page 12 applied to the client's back. When asked by the surveyor if the Primary Care Physician had been made aware of Client #6's refusals, the LPN was not able to produce any evidence.	W 368		
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered without error, for one of six clients residing the facility. (Client #4)</p> <p>The finding includes:</p> <p>Cross-refer W 368.2. The facility's medication nurse failed to ensure that Client #6's Nitroglycerin patch was administered as prescribed.</p>	W 369	<p>W369</p> <p>This Standard will be met as evidenced by:</p> <p>Cross reference response to W368.2.</p>	<p>12/17/09</p> <p>Ongoing</p>

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(1 000)	<p><b>INITIAL COMMENTS</b></p> <p>A revisit was conducted on December 3, 2009, through December 4, 2009, to verify the facility's compliance with condition level deficiencies cited during a complaint investigation dated October 16, 2009. A random sample of three clients was selected from a residential population of six females with various disabilities. The findings of the survey were based on observations in the home, interviews with direct care and nursing staff, as well as a review of the clinical, administrative, and habilitative records; including a review of the unusual incident reports.</p> <p>The revisit resulted in a determination that although progress had been made in correcting previously cited deficiencies, continuing condition-level deficiencies remained that preclude finding the facility in compliance with the Conditions of Participation in Governing Body and Health Care Services.</p> <p>On December 3, 2009, at approximately 5:40 p.m., the facility's Acting Qualified Mental Retardation Professional (AQMRP), Registered Nurse Supervisor, and Licensed Practical Nurse were notified that a client was observed coughing multiple times and spitting out large amounts of liquid during the evening meal. Based on further observation, interview and record verification, it was revealed that the facility's staff failed to effectively implement the client's mealtime protocol and the observed resident was at risk for aspiration. The facility was informed that the observed actions posed likely harm to the resident.</p> <p>On December 3, 2009, at approximately 8:40 p.m., the facility's AQMRP implemented and submitted to the State Agency (SA) a plan of</p>	(1 000)		

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

STATE FORM

TITLE

*[Signature]*

(X6) DATE

12/20/09

BTN613

If continuation sheet 1 of 15

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(1 000)	Continued From page 1 correction to address the identified concern as detailed below:  1. All staff and nurses present during the observed evening meal were trained on Resident #2's mealtime protocol. (Completed December 3, 2009)  2. The overnight staff will receive training on Resident #2's mealtime protocol. (Completed December 3, 2009)  3. The morning staff will receive training on Resident #2's mealtime protocol. (Completed December 4, 2009)  4. In addition, all staff in the home will receive follow-up training on mealtime protocols, adaptive feeding equipment, and the use of adaptive feeding equipment on an ongoing or as needed basis.  5. Nursing and management will monitor mealtimes to ensure that staff adhere to the protocols as outlined on a monthly basis.	(1 000)		
1 226	3510.5(c) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for one of six residents residing in the facility. (Resident #4)	1 226	1226  3510.5 Staff Training  This Statute will be met as evidenced by:  The facility nursing staff have been retrained on universal precautions while administering injections.  Also, reference response to W 192, and W331.	12/20/09

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1226	<p>Continued From page 2</p> <p>The finding includes:</p> <p>The facility's nursing staff failed to utilize standard nursing practices by ensuring universal precautions were implemented while administering Resident #4's injections.</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated November 18, 2009, the facility documented that additional staff training had been completed November 24, 2009 on infection control and maintaining sanitary conditions including the use of gloves and hand washing at all times.</p> <p>Observation on December 4, 2009, at 8:18 a.m., revealed the Registered Nurse (RN) injected Resident #4 with eight units of Novolog without wearing gloves. Further observation revealed the RN wiped the punctured area with an alcohol pad.</p> <p>Interview with the RN on December 4, 2009, at approximately 10:00 a.m., revealed that "there was no need to wear gloves because body fluids are not exchanged." Review of the medication administration policy/procedures on December 4, 2009, at approximately 10:45 a.m., revealed that gloves were required when administering external medications.</p>	1226	<p>1229</p> <p>3510.5(f) Staff Training</p> <p>This Statute will be met as evidenced by:</p> <p>Cross reference W192.</p> <p>2. Cross refer to W331.2.</p> <p>3. Cross refer to response for W192, W318, 368.</p>	<p>12/20/09</p> <p>ongoing</p>
{1229}	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(f) Specialty areas related to the GHMRP and the</p>	{1229}		

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(I 229)	<p>Continued From page 3</p> <p>residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure each employee providing direct care and nursing services were competently trained to implement mealtime protocols and calculate fluid restrictions, for three of six clients residing in the facility. (Residents #2, #3, and #4) This failure posed likely harm to the clients' health and safety. Additionally, the facility failed to ensure nursing staff were effectively trained to administer injections while adhering to universal precautions and standard nursing practices, for one of resident residing in the facility. (Resident #4)</p> <p>The findings include:</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC, the facility documented that staff would receive additional training on ensuring consistency with mealtime protocols in accordance with the Physician's Orders. Additionally, the POC documented that nurses would accurately implement/document client's fluid restriction as prescribed.</p> <p>1. The direct care and nursing staff failed to demonstrate competency in implementing Resident #2's mealtime protocol as detailed below:</p> <p>Observations during dinner on December 3,</p>	(I 229)		

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(I 229)	<p>Continued From page 4</p> <p>2009, beginning at 5:45 p.m., revealed Resident #2 was being assisted by Staff #1 to eat her meal. The meal consisted of pureed pork chops, string beans, zucchini, and cranberry grape juice. At 5:46 p.m., the House Manager (HM) was observed to assist Resident #2 with drinking her cranberry juice using hand over hand assistance. When the HM looked away momentarily, Resident #2 independently began to drink and was observed to take a large gulp of four (4) ounces of juice. Resident #2 immediately started to cough multiple times as a large amount of liquid spilled from both sides of her mouth. Prior to the resident coughing, the surveyor observed staff taking the spout lid off of the client's cup while assisting the client with drinking her juice. The nurse immediately intervened by telling the staff to stop feeding until Resident #2 cleared her throat. Once the client stopped coughing, the nurse went to retrieve more cranberry juice. The nurse then gave the staff member the cup of juice (without the spout lid) and that staff member resumed feeding the client and assisting her with drinking without the spout lid on the cup. At that time, the surveyor immediately intervened by informing the Acting QMRP/Assistant Director of Residential Services, who was on site, that the client was being fed juice without the benefit of the spout lid. The AQMRP intervened by stopping staff from continuing to allow Resident #2 to drink without the spout lid and placed the lid onto the cup.</p> <p>Interview with Staff #2 at 5:57 p.m., revealed that Resident #2 did not use the spout lid and the only reason the spout lid was initially on the cup was because the cup of juice was being refrigerated. When interviewed regarding what the spout lid was used for, the staff revealed that the spout lid was necessary to decrease the flow of fluid while</p>	(I 229)		

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(I 229)	<p>Continued From page 5</p> <p>drinking. At approximately 6:00 p.m., interview with the HM revealed that the spout cup was discontinued but, there was no documented evidence to support the HM's statement.</p> <p>Review of Resident #2's mealtime protocol dated October 2, 2009, on December 3, 2009, at approximately 5:50 p.m., (which was noted to be on the table during the dinner meal), indicated that Resident #2 was at risk for aspiration and identified special feeding equipment (open handled mug with spout lid). Interview with the AQMRP/Director of Residential Services on December 4, 2009, at approximately 10:30 a.m., revealed that staff was trained on Resident #2's mealtime protocol. Record review on December 4, 2009, at approximate 2:45 p.m., confirmed that staff was trained on Resident #2's mealtime protocol on November 30, 2009. There was no evidence that training had been effective.</p> <p>It should be noted that this is a repeat deficiency.</p> <p>2. Cross-refer to W 331.2. The facility's nursing services failed to ensure that each licensed staff had received effective training on procedures to properly implement/document Resident #3's fluid restriction as ordered by the Primary Care Physician (PCP).</p> <p>On December 3, 2009, at approximately 6:15 p.m., Resident #3 was observed to drink eight (8) ounces of beverage during the dinner meal. Review of Resident #3's mealtime protocol dated September 30, 2009, after dinner revealed the client was prescribed a 1500cc/day fluid restriction.</p> <p>Review of the December 2009 Fluid Intake Monitoring Sheets (FIMS) on December 4, 2009,</p>	(I 229)		

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(I 229)	<p>Continued From page 6</p> <p>at approximately 2:30 p.m., revealed the facility's nursing staff documented Resident #3's fluid intake during the month of November 2009 as detailed below:</p> <p>a. Resident #3 received less than 1500 cc fluids on November 2, 2009 (1270 cc), November 14, 2009 (1200 cc), November 17, 2009 (1440 cc), November 20, 2009 (1240 cc), and November 22, 2009 (1470 cc).</p> <p>b. Resident #3's FIMS documented she received over the 1500 cc fluid allotment for twenty-four (24) days. For example;</p> <ul style="list-style-type: none"> <li>- On November 5, 2009, the client received a total of 1890 cc of fluids.</li> <li>- On November 13, 15, and 16, 2009, the client received a total of 1680 cc's of fluids.</li> <li>- On November 18, 19, 20, 23, 24, 25, 26, and 27, 2009, the client received a total of 1650 cc's of fluids daily.</li> </ul> <p>Continued record review of Resident #3's Physician's Orders and interview with the facility's Registered Nurse (RN) and Acting QMRP/Assistant Director of Residential Services on the same day at approximately 3:20 p.m., verified that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's FIMS revealed that staff inaccurately documented a total of 1500 cc's daily for the entire month of November 2009. Further interview with the RN and Acting QMRP acknowledged the fluid intake monitoring sheets were inaccurate for November 2009 and the facility was not adhering to the 1500 cc of fluid daily as prescribed. Additional interview with the</p>	(I 229)		
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(I 229)	<p>Continued From page 7</p> <p>Acting QMRP revealed that all direct care and nursing staff had received training on fluid restrictions documentation.</p> <p>Review of the in-service training records on December 4, 2009, at approximately 4:25 p.m., revealed staff were trained on fluid intake/restrictions documentation on November 20, 2009. There was no evidence that training had been effective.</p> <p>It should be noted that this is a repeat deficiency.</p> <p>3. The facility's nursing staff failed to utilize standard nursing practices by ensuring universal precautions were implemented while administering Resident #4's injections.</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated November 18, 2009, the facility documented that additional staff training had been completed November 24, 2009 on infection control and maintaining sanitary conditions including the use of gloves and hand washing at all times.</p> <p>Observation on December 4, 2009, at 8:18 a.m., revealed the Registered Nurse (RN) injected Resident #4 with eight units of Novolog without wearing gloves. Further observation revealed the RN wiped the punctured area with an alcohol pad.</p> <p>Interview with the RN on December 4, 2009, at approximately 10:00 a.m., revealed that "there was no need to wear gloves because body fluids are not exchanged." Review of the medication administration policy/procedures on December 4,</p>	(I 229)		

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{1 229}	Continued From page 8 2009, at approximately 10:45 a.m., revealed that gloves were required when administering external medications.	{1 229}		
{1 401}	<p><b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b></p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with each client's needs, for four of the six residents residing in the facility. (Residents #2, #3, #4, and #6)</p> <p>The findings include:</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated November 18, 2009, the facility documented that nurses accurately implement/document residents fluid restriction as prescribed.</p> <p>1. The direct care and nursing staff failed to demonstrate competency in implementing Resident #2's mealtime protocol as detailed below:</p> <p>Observations during dinner on December 3, 2009, beginning at 5:45 p.m., revealed Resident #2 was being assisted by Staff #1 to eat her meal. The meal consisted of pureed pork chops,</p>	{1 401}	<p><b>3520.3 Profession Services: General Provisions</b></p> <p>This Statute will be met as evidenced by:</p> <p>Reference responses to W192.3, #2 and W368 for #1,2,and 3</p> <p><b>3522.4 Medications</b></p>	<p>12/2009 ongoings</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 12/04/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(I 401)	<p>Continued From page 9</p> <p>string beans, zucchini, and cranberry grape juice. At 5:46 p.m., the House Manager (HM) was observed to assist Resident #2 with drinking her cranberry juice using hand over hand assistance. When the HM looked away momentarily, Resident #2 independently began to drink and was observed to take a large gulp of four (4) ounces of juice. Resident #2 immediately started to cough multiple times as a large amount of liquid spilled from both sides of her mouth. Prior to the client coughing, the surveyor observed staff taking the spout lid off of the resident's cup while assisting the client with drinking her juice. The nurse immediately intervened by telling the staff to stop feeding until Resident #2 cleared her throat. Once the client stopped coughing, the nurse went to retrieve more cranberry juice. The nurse then gave the staff member the cup of juice (without the spout lid) and that staff member resumed feeding the client and assisting her with drinking without the spout lid on the cup. At that time, the surveyor immediately intervened by informing the Acting QMRP/Assistant Director of Residential Services, who was on site, that the client was being fed juice without the benefit of the spout lid. The AQMRP intervened by stopping staff from continuing to allow Resident #2 to drink without the spout lid and placed the lid onto the cup.</p> <p>Interview with Staff #2 at 5:57 p.m., revealed that Resident #2 did not use the spout lid and the only reason the spout lid was initially on the cup was because the cup of juice was being refrigerated. When interviewed regarding what the spout lid was used for, the staff revealed that the spout lid was necessary to decrease the flow of fluid while drinking. At approximately 6:00 p.m., interview with the HM revealed that the spout cup was discontinued but, there was no documented</p>	(I 401)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 12/04/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019
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{1401}	<p>Continued From page 10</p> <p>evidence to support the HM's statement.</p> <p>Review of Resident #2's mealtime protocol dated October 2, 2009, on December 3, 2009, at approximately 5:50 p.m., (which was noted to be on the table during the dinner meal), indicated that Resident #2 was at risk for aspiration and identified special feeding equipment (open handled mug with spout lid). Interview with the AQMRP/Director of Residential Services on December 4, 2009, at approximately 10:30 a.m., revealed that staff was trained on Resident #2's mealtime protocol. Record review on December 4, 2009, at approximate 2:45 p.m., confirmed that staff was trained on Resident #2's mealtime protocol on November 30, 2009. There was no evidence that training had been effective.</p> <p>It should be noted that this is a repeat deficiency.</p> <p>2. The facility's nursing services failed to ensure that each licensed staff had received effective training on procedures to properly implement/document Resident #3's fluid restriction as ordered by the Primary Care Physician (PCP).</p> <p>On December 3, 2009, at approximately 6:15 p.m., Resident #3 was observed to drink eight (8) ounces of beverage during the dinner meal. Review of Resident #3's mealtime protocol dated September 30, 2009, after dinner revealed the client was prescribed a 1500cc/day fluid restriction.</p> <p>Review of the December 2009 Fluid Intake Monitoring Sheets (FIMS) on December 4, 2009, at approximately 2:30 p.m., revealed the facility's nursing staff documented Resident #3's fluid intake during the month of November 2009 as</p>	{1401}		
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 12/04/2009
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(I 401)	<p>Continued From page 11 detailed below:</p> <p>a. Resident #3 received less than 1500 cc fluids on November 2, 2009 (1270 cc), November 14, 2009 (1200 cc), November 17, 2009 (1440 cc), November 20, 2009 (1240 cc), and November 22, 2009 (1470 cc).</p> <p>b. Resident #3's FIMS documented she received over the 1500 cc fluid allotment for twenty-four (24) days. For example:</p> <ul style="list-style-type: none"> <li>- On November 5, 2009, the client received a total of 1890 cc of fluids.</li> <li>- On November 13, 15, and 16, 2009, the client received a total of 1680 cc's of fluids.</li> <li>- On November 18, 19, 20, 23, 24, 25, 26, and 27, 2009, the client received a total of 1650 cc's of fluids daily.</li> </ul> <p>Continued record review of Resident #3's Physician's Orders and interview with the facility's Registered Nurse (RN) and Acting QMRP/Assistant Director of Residential Services on the same day at approximately 3:20 p.m., verified that Resident #3 was prescribed a fluid restriction of 1500 cc of fluid daily. Review of Resident #3's FIMS revealed that staff inaccurately documented a total of 1500 cc's daily for the entire month of November 2009. Further interview with the RN and Acting QMRP acknowledged the fluid intake monitoring sheets were inaccurate for November 2009 and the facility was not adhering to the 1500 cc of fluid daily as prescribed. Additional interview with the Acting QMRP revealed that all direct care and nursing staff had received training on fluid restrictions documentation.</p>	(I 401)		

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE WASHINGTON, DC 20019
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(I 401)	<p>Continued From page 12</p> <p>Review of the in-service training records on December 4, 2009, at approximately 4:25 p.m., revealed staff were trained on fluid intake/restrictions documentation on November 20, 2009. There was no evidence that training had been effective.</p> <p>It should be noted that this is a repeat deficiency.</p> <p>3. The facility's nursing staff failed to utilize standard nursing practices by ensuring universal precautions were implemented while administering Resident #4's injections.</p> <p>On November 18, 2009, the facility submitted a Plan of Correction (POC) to address deficiencies cited as a result of the October 16, 2009 investigation/survey. According to the POC dated November 18, 2009, the facility documented that additional staff training had been completed November 24, 2009 on infection control and maintaining sanitary conditions including the use of gloves and hand washing at all times.</p> <p>Observation on December 4, 2009, at 8:18 a.m., revealed the Registered Nurse (RN) injected Resident #4 with eight units of Novolog without wearing gloves. Further observation revealed the RN wiped the punctured area with an alcohol pad.</p> <p>Interview with the RN on December 4, 2009, at approximately 10:00 a.m., revealed that "there was no need to wear gloves because body fluids are not exchanged." Review of the medication administration policy/procedures on December 4, 2009, at approximately 10:45 a.m., revealed that gloves were required when administering external medications.</p>	(I 401)		

Health Regulation Administration

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(I 401)	Continued From page 13  4. The facility's medication nurse failed to ensure that Resident #4's medication was administered as prescribed.  Observation of the medication administration on December 4, 2009, at 8:18 a.m., revealed Resident #4 was administered Synthroid. Review of the Medication Administration Record (MAR) and current Physician's Orders dated December 2009, after the medication administration at approximately 9:30 a.m., revealed the aforementioned medication should have been administered between 5:00 a.m. and 7:00 a.m.  Interview with the License Practical Nurse (LPN) on December 4, 2009, at approximately 10:00 a.m., revealed Resident #4 should have received the Synthroid medication no later than 7:00 a.m.	(I 401)		
(I 473)	3522.4 MEDICATIONS  The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.	(I 473)	This Statute will be met as evidenced by:  Medications  Reference response to W368.	12/20/09 ongoing

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(I 473)	Continued From page 14  This statute is not met as evidenced by: Based on observation, interview and record review, the GHRP failed to ensure that any irregularities in the drug regimen was reported to the prescribing physician for one of six residents residing in the GHRMP. (Resident #5)  The findings include:  The facility's medication nurse failed to ensure that Resident #5's Nitroglycerin patch was administered as prescribed.  On December 4, 2009, at approximately 6:50 a.m., the LPN was observed to sign and date the Nitroglycerin patch. The LPN was then observed to apply Resident #5's Nitroglycerin patch to her back. Review of Resident #5's December 2009 MAR and December 2009 Physician's Orders after the medication administration at approximately 9:35 a.m., revealed the Nitroglycerin patch should have been applied to Resident #5's chest wall.  Interview with the LPN on the same day at approximately 10:00 a.m., revealed that Resident #5 would removed the Nitroglycerin patch when placed on her chest and therefore, the patch was applied to the client's back. When asked by the surveyor if the Primary Care Physician had been made aware of Resident #5's refusals, the LPN was not able to produce any evidence.	(I 473)			

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health**



Health Regulation &  
Licensing Administration

DEC 11 2009

Sent via Email and US Mail

Mr. Ron Raghunandan, CEO/CFO  
Individual Development, Inc.  
1420 N Street, N.W., Suite 9  
Washington, DC 20005

RE: 431 53<sup>rd</sup> Street, NE

Dear Mr. Raghunandan:

On December 4, 2009, a follow-up survey was conducted at your facility identified above, to determine if your facility had regained compliance with the Federal Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). The revisit resulted in a finding that even though progress had been made in correcting previously cited condition level deficiencies that resulted in the proposed enforcement action, continuing condition-level and standard-level deficiencies remained and preclude finding your facility in compliance with the requirements.

Enclosed are continuing deficiencies. You have an opportunity to submit a second credible allegation of compliance; however, you must submit documentation to support this allegation. Once the allegation of compliance has been received and approved, surveyor(s) from this office will revisit your facility to verify compliance. If the revisit results in a determination that you have corrected the deficiencies and your facility is in substantial compliance with the Conditions of Participation, this office will recommend to the Department of Health Care Finance (DHCF), the renewal of your Provider's Agreement.

This office will recommend termination of your federal participation if (1) this office does not receive a credible allegation of compliance by December 21, 2009 or (2) if you submit a credible allegation of compliance, but are found not to have been in substantial compliance by December 21, 2009. We will recommend that the termination date will be December 29, 2009 ninety (90 days) after the survey completion date.

2

Should the Health Regulation and Licensing Administration recommend termination of your federal participation, the DHCF will contact you with its determination. The DHCF will also apprise you of your hearing rights pursuant to 42 CFR 431.151-154.

Please note that, if your participation in the Medicaid program is terminated, your facility will not be readmitted to the program unless you can demonstrate to this office that the reason for termination has been removed, and there is a reasonable assurance that it will not recur.

If you have any questions regarding this matter, please contact Laura A. Hunts, Supervisory Health Service Program Specialist on Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,



Sharon H. Mebane  
Program Manager

Enclosures

Cc: Fescha Woldu, PhD  
Senior Deputy Director  
Department of Health

Carmen Johnson  
Assistant Attorney General  
Office of Attorney General

Michael Cheek  
Office of Chronic & Long-Term Care  
Department of Health Care Finance

Laura L. Nuss  
Deputy Director  
Department on Disability Services

Shannon Randall, PhD  
Quality Enhancement Improvement Manager  
Department on Disability Services

Paul Smith  
Director, Quality Management  
Department on Disability Administration