

1-19-10

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION ADMINISTRATION  
625 NORTH CAPITOL ST., N.E., 2ND FLOOR  
A. BUILDING WASHINGTON, D.C. 20002

PRINTED: 01/08/2010  
FORM APPROVED  
OMB NO. 0936-0391

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
  
09G130

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

(X2) DATE SURVEY  
COMPLETED  
  
12/18/2009

NAME OF PROVIDER OR SUPPLIER  
  
INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE  
6529 1ST STREET, NW  
WASHINGTON, DC 20012

(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	INITIAL COMMENTS	W 000	W104	
	<p>A recertification survey was conducted from December 16, 2009 through December 18, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of six females with various disabilities. Additionally, a focused review was conducted for two of the remaining three clients.</p> <p>The findings of the survey were based on observations in the home and three day programs, interviews with staff in the home and day programs, as well as a review of the clinical, administrative, and habilitation records; including a review of the unusual incident/investigation reports.</p>		<p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>The governing body has established a protocol that outlines the use of portable and emergency oxygen. The RN is required to review all recommendations, protocols and procedures prior to implementation with the Director of Nursing. All protocols established will be reviewed and approved by the governing body to include but limited to the Medical Director, Director of Nursing and Administrators. The Director of Nursing and assigned RN will conduct competency training for the nursing staff on the use and parameters/guidelines on the use of the portable and emergency oxygen.</li> </ol>	1-18-10
W 104	<p>483.41 (a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and review of records the facility's governing body provided general operating direction over the facility, except for one of the three sampled clients. (Client #1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The governing body failed to establish a protocol that outlined the use of portable and emergency oxygen prior to its implementation.</li> </ol> <p>Upon entry into the facility on December 16, 2009, the surveyors were informed that Client #1</p>	W 104		
<p>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ DATE 1/18/10</p>				

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 44 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continuing program participation.

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
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W 104	Continued From page 1 required the use of oxygen nightly, and the use of portable oxygen when necessary to aide with the client's chronic obstructive pulmonary disease (COPD) symptoms. Review of the agency's Nursing policy and procedure record on December 16, 2009 at 4:00 p.m. and the agency's operating policy and procedure record on December 18, 2009 at 10:00 a.m. failed to evidence an established policy that outlined the use of portable and emergency oxygen.  2. Interview conducted with the facility's Register Nurse (RN) and consultant Qualified Mental Retardation Professional on December 18, 2009, at approximately 12:05 p.m., verified the agency did not have an established policy on the use of portable and emergency oxygen use. Note: On the final day of survey, the RN developed a draft policy titled "Oxygen Administration-Nasal Cannula Policy" that outlined procedures for implementation. At the conclusion of the survey, there was no evidence that the medical director and the agency's administrator had reviewed or finalized the aforementioned proposed policy.  3. Cross refer to W192. The governing body failed to ensure the proper documentation of staff competency in oxygen therapy.	W 104	2. Reference response to #1. 3. Cross reference response to W192.	1.8.10	
W 114	483.411(c)(4) CLIENT RECORDS  Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all persons making entries into the clients' records were dated and signed, for two of the three clients in the sample. (Client	W 114			

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W 114	<p>Continued From page 2</p> <p>#1 and Client #3) and one of two focused clients. (Client #4)</p> <p>The findings include:</p> <p>1. Review of Client #3's medical record on December 17, 2009, at approximately 2:30 p.m., revealed a nursing quarterly assessment completed October 2009 with no signature. The observation was brought to the attention of the facility nurses at approximately 10:00 a.m. who acknowledged that the nursing quarterly assessment was not signed by the author.</p> <p>2. Review of Client #1's medical record on December 17, 2009 at approximately 2:15 p.m., revealed several documents that were not signed or dated as evidenced below:</p> <p>a. Record review revealed a hand written physician order dated January 28, 2009 indicating the following: "Continue Pulmicort nebs twice a day, Albuterol nebs q 6h x 48 hours then as needed (please give her a nebs treatment when she wheezes), Oxygen 2L NE when O2 sats &lt; 88%, D/C combivent her Inhaler." Further review revealed the transcriber failed to reflect the time, the manner received (via prescription or telephone order) and by whom.</p> <p>b. Review of Client #1's medical record evidenced a hand written order prescribing "Lasix 10 mg po give 2 tabs for 5 days, then continue with tab QD." There was no date or time indicated, or prescriber indicated on the order. In addition, the physician had failed to sign the order.</p> <p>During a face-to-face interview on December 17,</p>	W 114	<p>W114</p> <p>This Standard will be met as evidenced by:</p> <p>1. The Director of Nursing will conduct additional training for the assigned RN and monitor for compliance. The quarterly assessment has been signed and dated. The RN is expected to conduct weekly record reviews to ensure that all documents are signed and dated and assigned nursing staff are able to demonstrate competencies in transcription to include dates, times and signatures. The RN will conduct training for the nurses assigned to the home and monitor for compliance. Future, occurrences will result in disciplinary action.</p>	1.7.10 01/19/2010	

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W 114	<p>Continued From page 3</p> <p>2009 at approximately 3:00 p.m., the LPN acknowledged the aforementioned orders had not been dated and signed off by the author and by the primary care physician.</p> <p>c. Client #1's Abnormal Involuntary Movement Scale (AIMS) assessment dated February 1, 2009 failed to evidence the signature of the author that completed the assessment.</p> <p>3. Review of Client #4's medical record on December 17, 2009, at 2:00 p.m., revealed a Health Management Care Plan (HMCP) dated December 1, 2009, that was not dated and signed off by the author.</p> <p>During a face-to-face interview on December 17, 2009, at approximately 2:05 p.m., the RN acknowledged the HMCP had not been dated and signed off by the author.</p> <p>4. Review of Client #4's medical record on December 17, 2009 at 2:10 p.m., revealed a Health Service Summary (HSS) dated December 1, 2009, that was not dated and signed off by the author. Further review revealed the author had typed in their name.</p> <p>During a face-to-face interview on December 17, 2009, at approximately 2:20 p.m., the RN acknowledged the HSS had not been dated and signed off by the author.</p> <p>There was no documented evidence the HSS was dated and signed off by the author.</p>	W 114	<ol style="list-style-type: none"> <li>2. Reference response to the #1. The RN will review all records to ensure compliance with this standard. (a., b., c.)</li> <li>3. Reference response to #1. HMCP has been dated and signed.</li> <li>4. The Health Service Summary has been signed and dated. Also reference #1.</li> </ol>	1-7-10 original	
W 138	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS</p>	W 138			

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W 135 Continued From page 4

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to ensure the opportunity to participate in a variety of community activities, for one of the three clients in the sample. (Client #2)

The finding includes:

On the evening of December 17, 2009 at 5:15 p.m., staff was observed preparing several of the clients to leave the facility. Interview with the staff revealed that the clients were going to the Chateau Lounge, to which they alternate turns attending. The staff and the facility coordinator (FC) indicated that Client #2 had also been provided the opportunity to participate in other recreational outings during the year. The FC stated that staff should document the date and time of all recreational outings provided for the clients in their program books.

The review of Client #2's recreation log in the program book on December 17, 2009 at 2:05 p.m. revealed the following outings:

- May 2009 - 0
- June 2009 - 0
- July 2009 - Barbershop
- August 2009 - 0
- September 2009 - 0
- October 15 and 29, 2009 - Chateau Lounge
- October 23, 2009 - Museum
- November 5, 2009 - Chateau Lounge

W136

This Standard will be met as evidenced by:

The QMRP and Coordinator will receive additional training on providing opportunities for people to participate in social, religious, and community group activities. The Coordinator must demonstrate that all persons have participated and in a variety of community events as evidenced by the "Weekly Community Outing Form" which will be monitored by the QMRP and DRS.

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W 136	Continued From page 5 November 19, 2009 - Out of town vacation with housemates.  On December 18, 2009 at 12:50 p.m., the FC indicated that she would talk with staff to determine if any outings had been documented in a different location in the client's record. At the time of the survey, however, no further documentation of outings was provided for review. There was no evidence the client had been regularly provided the opportunity to participate in a variety of recreational activities.	W 136			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services for four of the six clients residing in the facility. (Clients #1, #2, #4 and #5)  The findings include:  1. The facility's QMRP failed to ensure the opportunity to participate in a variety of community activities for Client #2. [See W136]  2. The facility's QMRP failed to coordinate services to ensure each employee was provided with initial and continuing training that enabled them to effectively address the health care needs of Clients #1 and #5. [See W189]	W 159	W159 This Standard will be met as evidenced by:  1. Reference response to W136. 2. Reference response to W189. 3. Reference response to W192. 4. Reference response to W214. 5. Reference response to W249. 6. Reference response to W252.	1-18-10	

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W 159	Continued From page 6  3. The facility's QMRP failed to coordinate services to ensure that employees who work with clients were trained on skills and competencies directed toward clients' health needs of Clients #1 and #4. [See W192]  4. The facility's QMRP failed to coordinate services to obtain a comprehensive functional assessment to identify the specific developmental and behavioral management needs of Clients #1 and #3. [See W214]  5. The facility's QMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for Client #2. [See W249]  6. The QMRP failed to coordinate services to ensure accurate documentation of Client #2's program objectives. [See W252]	W 159		
W 192	483.431(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 employees who work with clients, were trained on skills and competencies directed toward clients' health needs, for one of three clients in the sample (Client #1) and two of two focus clients. (Client #4 and #5)  The findings include:	W 192	<p><b>W192</b> This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Reference response to W104.</li> <li>2. All staff will receive training on rectal bleeding monitoring, documenting, reporting observations and incidents of rectal bleeding. Documentation of all training will be maintained in the home and within the training department to ensure that training can be verified upon request.</li> </ol>	1-15-10

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W 192	<p>Continued From page 7</p> <p>1. During an environmental observation on December 17, 2009, at approximately 10:00 a.m., Client #1 had an unplugged oxygen canister with a covered nasal cannula beside her bed.</p> <p>During a face to face interview with LPN #2 on December 17, 2009, at approximately 10:30 a.m., it was revealed Client #1 was administered oxygen two (2) liters at night. Further interview revealed that all staff had been trained on the client's oxygen therapy protocol.</p> <p>Review of Client #1's physician's orders (POS) dated December 1, 2009, approximately 11:10 a.m., revealed an order for oxygen two (2) liters via nasal cannula if pulse oxygen is less than ninety (90%). Further review revealed oxygen two (2) liters via nasal cannula to keep oxygen sats (saturation) greater than eighty-eight (88%) whenever necessary and every night.</p> <p>Review of the facility's training records on December 17, 2009, at approximately 4:00 p.m. and on December 18, 2009, at approximately 10:20 a.m., revealed no evidence of Client #1's training on oxygen therapy protocol.</p> <p>During a face-to-face interview with the Registered Nurse on December 18, 2009, at approximately 10:30 a.m., it was acknowledged there was no sign-in sheets and agendas on oxygen therapy protocol in the training manuals.</p> <p>There was no documented evidence the facility's staff was trained on skills and competencies directed toward the clients' health needs.</p> <p>2. Review of Client #4's hospital Summary Report</p>	W 192	<p>3. QMRP in coordination with RN and Coordinator will schedule training for all staff urinary tract infections, water and soap skin cleansing and monitoring for signs and symptoms of infection.</p> <p>4. Reference #3. Training will include incontinence/peri-care. Training will be implemented monthly. QMRP, Coordinator and Nursing staff will continue to monitor for ongoing compliance to ensure that staff are able to perform their duties effectively.</p>	1.5.10 01/19/2010	

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W 192	<p>Continued From page 8</p> <p>dated July 13, 2009, on December 17, 2009, at approximately 11:05 a.m., revealed Client #4 was admitted into the hospital on July 7, 2009, and discharged on July 13, 2009. Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. Client #4's discharge diagnosis included acute or chronic anemia.</p> <p>Review of Client #4's Health Management Care Plan dated December 1, 2009, at approximately 2:05 p.m., revealed training was required to monitor for rectal bleeding.</p> <p>Review of the facility's training records on December 17, 2009, at approximately 2:00 p.m. and on December 18, 2009, at approximately 2:20 p.m., revealed no training on monitoring for rectal bleeding.</p> <p>During a face-to-face interview with the RN on December 18, 2009, at approximately 2:35 p.m., it was revealed staff was trained on monitoring of rectal bleeding. Further interview revealed there were no sign-in sheets and agendas on monitoring for rectal bleeding in the training manuals.</p> <p>There was no documented evidence the facility's staff was trained on skills and competencies directed toward the clients' health needs.</p> <p>3. Review of Client #5's Medical Assessment dated May 1, 2009, on December 18, 2009, at approximately 11:22 a.m., revealed Client #5 has diagnoses that include recurrent urinary tract</p>	W 192			

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W 192	<p>Continued From page 8 infections (UTI's).</p> <p>Review of urine culture and sensitivity laboratory studies revealed Client #5 had urinary tract infections every month excluding May 2009, from December 22, 2008 to October 1, 2009.</p> <p>Review of Client #5's medical record on December 18, 2009, at approximately 3:30 p.m., revealed a Health Management Care Plan (HMCP) dated April 28, 2009, that documented recommendations including the following: to maintain regular one to two hourly diaper changes provide water and soap skin cleansing with each diaper change, monitor vulva area for signs of infection (redness, rashes and swelling).</p> <p>Review of the facility's training records on December 18, 2009, at approximately 3:45 p.m., revealed the only documented staff training on Incontinence/peri-care was on October 13, 2009.</p> <p>During a face-to-face interview with the consulting Qualified Mental Retardation Professional (QMRRP) on December 18, 2009, at approximately 3:58 p.m., it was acknowledged additional training was needed in the area of incontinence/peri-care.</p> <p>There was no documented evidence of continuing training enabling the employees to perform their duties effectively, efficiently, and competently.</p> <p>4. Review of Client #1's Medical Assessment dated November 5, 2009, on December 17, 2009, at approximately 1:00 p.m., revealed Client #1 had diagnoses that include Acute Cystitis, and a history of recurrent Urinary Tract Infections. (UTI's).</p>	W 192		
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W 192	Continued From page 10  Review of urine culture and sensitivity laboratory studies and review of physician orders from December 2008 through December 2009 revealed Client #1 had urinary tract infections that required treatment in December 2008, February 2009 x 2, April 2009, June 2009, October 2009, and December 2009.  Review of Client #1's medical record on December 18, 2009, at approximately 2:30 p.m., revealed a Health Management Care Plan (HMCP) dated October 30, 2009, and reviewed on December 12, 2009, revealed a recommendation to encourage adequate daily fluid intake, monitor for signs of UTI (fever, highly concentrated urine, decreased urine output), and monitor response to treatment. Further review of the medical record reveal urology consults dated August 24, 2009, June 24, 2009, and February 13, 2009, recommending increased fluid intake, change often, good genital hygiene and toileting regime.  Review of the facility's training records on December 18, 2009, at approximately 3:45 p.m., revealed the only documented staff training on incontinence/perf-care was on October 13, 2009.  During a face-to-face interview with the Consulting Mental Retardation Professional (CQMRP) on December 18, 2009, at approximately 3:58 p.m., it was acknowledged additional training was needed in the area of incontinence/perf-care.  There was no documented evidence of continuing training enabling the employees to perform their duties effectively, efficiently, and competently.	W 192			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETE?  12/19/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6630 1ST STREET, NW WASHINGTON, DC 20012
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W 214	<p><b>483.440(c)(3)(ii) INDIVIDUAL PROGRAM PLAN</b></p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive functional assessment of specific developmental and behavioral management needs for two of three clients in the sample. (Client #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation of the morning medication administration on December 17, 2009, beginning at 6:35 a.m. revealed Client #1 received medications including Naltrexone. Interview with the medication nurse during the medication administration, revealed the aforementioned medication was used to address the client's behaviors.</li> </ol> <p>Review of the Medication Administration Record (MAR) on December 17, 2009, revealed a Physician's Order dated December 1, 2009. Continued review of the order also revealed Client #1 was prescribed Zyprexa at nighttime to address behaviors. Interview with Qualified Mental Retardation Professional (QMRP) on December 18, 2009, at 12 noon verified that Client #1's medication was used to control behaviors in conjunction with a Behavior Support Plan (BSP).</p> <p>Continued interview with the QMRP was conducted to ascertain if Client #1 had a comprehensive psychiatric assessment to justify</p>	W 214	<p><b>W214</b></p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Client # 1's psychiatric assessment will be completed as required. The behavior support plan and prescribed medications will be reviewed and discussed at the next scheduled Human Rights Committee meeting. Informed consent for medications will be maintained on file. All staff will receive training on medications side effects and reason medications are prescribed. QMRP/Coordinator nursing staff will also monitor and address concerns as they arise.</li> <li>2. Reference response to #1.</li> </ol>	<p>1/18/10 01/19/10</p>

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6620 1ST STREET, NW WASHINGTON, DC 20012		
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W 214	Continued From page 12 the use of the behavior modification drugs and her corresponding psychiatric diagnoses (Schizophrenia). At the time of the survey, the facility failed to provide evidence that Client #1 received a comprehensive psychiatric assessment.  2. Observation of the morning medication administration on December 17, 2009, beginning at 6:35 a.m., revealed Client #3 received medications including Perphenazine. Interview with the medication nurse during the medication administration, revealed the aforementioned medication was used to address the client's behaviors.  Review of the Medication Administration Record (MAR) on December 17, 2009, revealed a Physician's Order dated December 1, 2009. Continued review of the order revealed Client #3 was prescribed Lexapro to address depression. Interview with Qualified Mental Retardation Professional (QMRP) on December 18, 2009, at 12:30 p.m. verified that Client #3's medication was used to control behaviors in conjunction with a Behavior Support Plan (BSP).  Continued interview with the QMRP was conducted to ascertain if Client #3 had a comprehensive psychiatric assessment to justify the use of the behavior modification drugs and her corresponding psychiatric diagnoses (Intermittent Explosive Disorder; Depression). At the time of the survey, the facility failed to provide evidence that Client #1 received a comprehensive psychiatric assessment.	W 214			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has	W 249			

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6620 1ST STREET, NW WASHINGTON, DC 20012		
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W 249	<p>Continued From page 13</p> <p>formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of three clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that Client #2's program goal designed to improve her standing tolerance was implemented as written, as evidenced below:</p> <p>Interview with staff on December 17, 2009, at 11:20 a.m., revealed that staff supervised Client #2 in standing up for 5 minutes every hour, when she is awake to improve her tolerance of standing. Staff indicated that the client's standing was incorporated during activities of daily living and at other times during the day as recommended by the physical therapist. According to staff, the client's standing should be documented in her program book. Interview with the Qualified Mental Retardation Professional (QMRP) on December 18, 2009, at 1:10 p.m. revealed that the client's participation in the objective was being monitored by the physical</p>	W 249	<p>W249</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. The QMRP in coordination with the Physical Therapist have implemented the recommended goal. The QMRP will conduct training for all staff and monitor program implementation as outlined. The Physical Therapist will also monitor progress and implementation of program objectives outlined as evidenced by direct observation, progress notes and written reports.</li> <li>2. Reference response to #1. Record reviews will be completed on a regular basis to further ensure that individual program goals are developed and needed interventions are implemented as recommended.</li> </ol>	1-17-10 omismine	

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W 249	<p>Continued From page 14 therapist.</p> <p>Record review on December 17, 2009, at 11:50 a.m. revealed on March 8, 2009, the IDT recommended a goal (March 2009 to March 2010), to "improve the client's tolerance of standing." According to the corresponding objective, the client "will stand for at least 5 minutes every 30 minutes that she is awake at 100% accuracy for one month." Subsequent review of the program data (for September, October, November and December 2009) at that time of the survey confirmed staff statements that the objective was implemented hourly. At the time of the survey, there was no evidence that the standing for five minutes had been implemented every thirty minutes as recommended by the IDT.</p> <p>2. The facility failed to ensure that Client #2's program goal designed to improve her trunk range of motion was implemented at the recommended frequency as evidenced below:</p> <p>Interview with staff on December 17, 2009 at 11:20 a.m. revealed that Client #2 was supposed to lie prone in her bed for 10 minutes. Further interview with staff revealed the number of minutes that the client was able to remain in the prone position should be documented in the morning and in the evening. Staff indicated that the client usually did not tolerate this position for more than five minutes.</p> <p>Review of the Individual Program Plan (IPP) on December 17, 2009, at approximately 12 noon, revealed the IDT recommended a goal (March 2009 to March 2010) a goal to improve Client #2's trunk range of motion. The objective stated the client "will tolerate the prone position for 10</p>	W 249			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G180	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 8520 1ST STREET, NW WASHINGTON, DC 20012		
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W 249	Continued From page 15 minutes at 100% accuracy for 6 months." In August 2009, Client #2 sustained an injury to her shoulder, which resulted in this program being temporarily on hold. Review of the Physical Therapy (PT) assessment on September 24, 2009, however, recommended that the objective be resumed. Record review revealed the objective was not resumed until November 2009. At the time of the survey, there was no evidence that Client #1's goal to improve her trunk range of motion was implemented as recommended.	W 249			
W 252	483.44)(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure data was collected in a manner to accurately measure progress on the individual program plan (IPP) objectives, for one of the three clients in the sample. (Client #2)  The findings include:  1. Cross refer to W249.1. The facility failed to collect data in measurable terms for Client #2's training objective designed to improve her standing tolerance as evidenced below:  Interview with the direct care staff on December 17, 2009, at 11:20 a.m. revealed that the staff supervised Client #2 in standing up for 5 minutes every hour when she is awake to improve her tolerance of standing.	W 252	W252 This Standard will be met as evidenced by: 1. Cross reference response to W249. 2. Cross reference response to W249. Data will be collected in the form and frequency required by the plan.	1-7-10	

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6830 1ST STREET, NW WASHINGTON, DC 20012		
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W 252	Continued From page 18  Record review revealed a goal to improve Client #2's standing tolerance. According to the IPP objective, the client "will stand for at least 5 minutes every 30 minutes that she is awake at 100% accuracy for one month." Although the IPP stated that the client should stand for 5 minutes every 30 minutes, the data collection form stated the program frequency was every hour. The times typed on the form were hourly (example: 6:00 a.m., 7:00 a.m...to 8:00 p.m.). There was no evidence that data was collected in a manner to determine if the client had stood or five minutes every 30 minutes.  2. Interview with the direct care staff on December 17, 2009, at 11:20 a.m., revealed Client #2 had a goal to improve her trunk range of motion. According to the objective, two times a day, the client "will tolerate the prone position for 10 minutes at 100% accuracy for 6 months." Interview with the staff on December 17, 2009, at approximately 12:10 p.m., revealed the program was implemented in the morning and the evening, however at times it was difficult for the client to remain in the prone position.  On December 18, 2009, at 9:50 a.m., the review of program data revealed the client had been able to tolerate the prone position for 5 minutes 32/34 provided opportunities during November 2009. Data collection for December 2009 however revealed the client had tolerated the prone position for 0 minutes on 17/20 provided opportunities for the first 10 days of the month. There was no documentation on the form concerning possible reasons why the client did not participate in the training. Although data collected for December 14, 15, and 16, 2009	W 252			

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W 252 Continued From page 17 indicated that the client tolerated 10 minutes of prone positioning in the p.m., no data was available for the morning on these dates. Additionally, no data was available after December 16, 2009, for the morning or evening.

W 322 483.460(a)(3) PHYSICIAN SERVICES

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure preventive health services were implemented as recommended for one of two focused in the facility. (Client #5)

The finding includes:

1. The primary care physician failed to clarify Client #5's hydration order as evidenced below:

On December 16, 2009, at 5:20 p.m., Client #5 was observed to consume approximately 95% of her solids and 16 oz of fluids during the dinner meal. During the medication administration on December 17, 2009, at 8:15 a.m., the client was observed to take her medications by mouth with apple juice.

Interview with the LPN on December 18, 2009, at 1:32 p.m. revealed that Client #5 received all food, supplement, medications and fluids by mouth, and no longer required her water to be administered via Gtube. The LPN indicated that the client should receive 12 cups of fluid daily.

W 252 W322

This Standard will be met as evidenced by:

1. The RN will ensure that the order for client #5 is clarified. The RN will review all recommendations made by the nutritionist and discuss with the primary care physician. PCP will address recommendations for client #5.
2. Urology consult information has been requested. The RN will follow-up with the urologist until received. The RN will provide additional training for LPN staff on monitoring and reviewing consult information immediately following the appointment. All LPN staff are expected to verify review and document the outcome of the scheduled appointments. RN will conduct record weekly reviews to ensure ongoing compliance.

1-7-10

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W 322	<p>Continued From page 18</p> <p>According to the annual nutritional assessment dated April 29, 2009, the client needed a minimum of 1830 cc fluid/day (30 cc/kg x 61 kg body weight). The review of the current physician's orders dated December 1, 2009, revealed a continuing order (initially dated 8/8/08) documented the following instructions for water: "Flush with 30 ml before and after each medication and between medications". The nurse initiated for each shift (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; 12:00 a.m. - 8:00 a.m.).</p> <p>At the time of the survey, there was no evidence the PCP had addressed the nutritionist fluid recommendations.</p> <p>2. The facility's nursing services failed to ensure timely medical follow-ups as recommended by the urologist.</p> <p>Review of Client #5's urology consult dated July 27, 2009, on December 18, 2009, at approximately 11:26 a.m., revealed a recommendation for Client #5 to have follow-up appointment in three (3) months.</p> <p>Review of Client #6's medical records on December 18, 2009, at approximately 11:57 a.m., revealed no follow-up urology appointment in the medical record.</p> <p>During a face to face interview with the RN on December 18, 2009, at approximately 3:00 p.m., it was revealed the client had gone to the urologist on October 30, 2009, however acknowledged the results of the urology consult was not in the medical record.</p>	W 322			
W 331	483.480(c) NURSING SERVICES	W 331			

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W 331	<p>Continued From page 19</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility's nursing staff failed to ensure nursing services in accordance with clients' needs for six of six clients in the facility. (Client #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The facility's nursing services failed to ensure the client's health status was recorded on the Medication Administration Record (MAR).</li> </ol> <p>Observation of medication administration on December 17, 2009, at approximately 7:30 a.m., revealed Licensed Practical Nurse #1 (LPN #1) administered Carvedilol 3.125 mg one tablet by mouth to Client #4.</p> <p>Review of the December, 2009, Medication Administration Record (MAR) on December 17, 2009, at approximately 12:00 p.m., revealed Client #4's apical pulse was recorded each time the medication was administered except on December 17, 2009, at 7:00 a.m.</p> <p>During a face to face interview with LPN #2 on December 17, 2009, at approximately 1:05 p.m., it was acknowledged Client #4's apical pulse was not recorded on the MAR for the aforementioned date.</p> <ol style="list-style-type: none"> <li>The facility's nursing services failed to ensure the results of medical studies were recorded in each client's medical record.</li> </ol>	W 331	<p>W331</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>The RN will conduct additional training and/ or implement disciplinary actions as needed to address non-compliance with recorded health status of client #4. The RN will monitor MAR's weekly and address concerns as they arise. The Director of Nursing will conduct random record reviews.</li> </ol>	1-7-10 original
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W 331	<p>Continued From page 20</p> <p>a. Review of Client #4's hospital Summary Report dated July 13, 2009, on December 17, 2009, at approximately 11:05 a.m., revealed Client #4 was admitted to the hospital on July 7, 2009, and discharged on July 13, 2009. Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. An esophagogastroduodenoscopy (EGD) was recommended to be performed while the client was in the hospital.</p> <p>Review of Client #4's medical records on December 17, 2009, at approximately 3:25 p.m., revealed the results of the EGD was not in the medical record.</p> <p>During face to face interviews with the RN and Consulting Qualified Mental Retardation Professional (CQMRP) on December 17, 2009, at approximately 4:10 p.m., and on December 18, 2009, at approximately 2:35 p.m., it was acknowledged the results of the EGD was not in the medical record. Further interview revealed the attending physician at the hospital was left a voice mail message in regarding obtaining the results of the EGD.</p> <p>b. Review of Client #4's hospital Summary Report dated July 13, 2009, on December 17, 2009, at approximately 11:06 a.m., revealed Client #4 was admitted to the hospital on July 7, 2009, and discharged on July 13, 2009. Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. A colonoscopy was recommended to be performed while the client was in the hospital.</p> <p>Review of Client #4's medical records on</p>	W 331	<p>W331</p> <p>2. The medical studies and laboratory studies will be reviewed and obtained. The RN will monitor and provide direction and feedback for the assigned LPN's to ensure that recommended studies are obtained in a timely manner. The LPN staff will receive additional training on adherence to laboratory schedules and updating master list of required laboratory studies. The Director of Nursing will conduct random record reviews to further ensure compliance with this standard.</p>	1-7-10 Ongoing

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 8620 1ST STREET, NW WASHINGTON, DC 20012		
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W 331	<p>Continued From page 21</p> <p>December 17, 2009, at approximately 3:25 p.m., revealed the results of the colonoscopy was not in the medical record.</p> <p>During face to face interviews with the RN and Consulting Qualified Mental Retardation Professional on December 17, 2009, at approximately 4:10 p.m., and on December 18, 2009, at approximately 2:35 p.m., it was acknowledged the results of the colonoscopy was not in the medical record. Further interview revealed the attending physician at the hospital was left a voice mail message in regarding obtaining the results of the colonoscopy.</p> <p>3. The facility's nursing services failed to ensure timely laboratory studies were performed as recommended by the urologist.</p> <p>a. Review of Client #5's urology consult dated July 27, 2009, on December 18, 2009, at approximately 11:25 a.m., revealed a recommendation for Client #5 to have a repeat C&amp;S (urine culture and sensitivity) study.</p> <p>Review of Client #5's laboratory studies on December 18, 2009, at approximately 11:55 a.m., revealed a urine culture and sensitivity study dated August 11, 2009 and the urine contained Escherichia Coli (E. Coli) and the client was prescribed Macrobid 100 mg twice a day for ten (10) days. Further review of urine culture and sensitivity laboratory studies revealed the client had urinary tract infections every month excluding May 2009, from December 22, 2008 to October 1, 2009.</p> <p>During a face-to-face interview with the RN on December 17, 2009, at approximately 4:05 p.m.,</p>	W 331	<ol style="list-style-type: none"> <li>3. Reference response to #2.</li> <li>4. Cross reference response to W192.</li> <li>5. Cross reference response to W368.</li> <li>6. Cross reference response to W371.</li> <li>7. Cross reference response to W381.</li> <li>8. Cross reference response to W455</li> </ol>	1-7-10 ongoing	

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6830 1ST STREET, NW WASHINGTON, DC 20012
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W 331	<p>Continued From page 22</p> <p>it was acknowledged the laboratory study was not performed timely.</p> <p>b. Review of Client #5's Medical Assessment dated May 1, 2009, on December 18, 2009, at approximately 11:20 a.m., revealed a recommendation for Client #5 to have urine culture and sensitivity laboratory studies every three months. Further review revealed the client has diagnoses that include recurrent urinary tract infections (UTI's).</p> <p>Review of Client #5's laboratory studies on December 18, 2009, at approximately 11:57 a.m., revealed a urine culture and sensitivity study was collected and recorded in the medical record for August 2009 and was positive for Escherichia Coli (E. Coli). Further review of the laboratory studies revealed a urine culture and sensitivity study was not collected and recorded in the medical record three months later in the month of November 2009.</p> <p>Review of urine culture and sensitivity laboratory studies revealed Client #5 had urinary tract infections every month excluding May 2009, from December 22, 2008 to October 1, 2009.</p> <p>During a face-to-face interview with the RN on December 18, 2009, at approximately 3:58 p.m., it was acknowledged the laboratory studies were not performed timely.</p> <p>4. Cross Refer to W 192. The facility's nursing services failed to ensure employees who work with the clients were trained on skills and competencies directed toward clients' health needs.</p>	W 331		

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W 331	Continued From page 23 5. Cross Refer to W 368. The facility's nursing services failed to ensure that all drugs were administered in compliance with the physician's orders 6. Cross Refer to W 371. The facility's nursing services failed to implement an effective system to ensure Client #3 participated in a self-medication training program. 7. Cross Refer to W 381. The facility's nursing services failed to store drugs under proper conditions of security. 8. Cross Refer to W 455. The facility's nursing services failed to provide an active program for the prevention and control of infection and communicable diseases.	W 331			
W 336	483.46(k)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client received a physical examination by a Registered Nurse at least quarterly, for two of the three clients in the sample. (Clients #3)  The finding includes:  The facility failed to ensure that a Registered Nurse (RN) on a quarterly or more frequent basis reviewed each client's health status as evidenced	W 336	W336 This Standard will be met as evidenced by: The RN has completed all quarterly assessments. The Director of Nursing will provide competency training for RN and review schedule. Disciplinary action will be implemented for the RN as needed if future incidents of non-compliance are observed. The Director of Nursing will conduct regular random reviews of the records, meet weekly with the RN staff, and address concerns as they arise.	1/10 ongoing	

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W 336	Continued From page 24 below	W 336			
W 368	<p>Review of Client #3's medical record on November 17, 2009 at 10:25 a.m., revealed an annual nursing assessment dated July 4, 2009. When interviewed on November 18, 2009, at approximately 1:00 p.m., the RN acknowledged that the quarterly assessment had been due on November 7, 2009.</p> <p><b>483.460(k)(1) DRUG ADMINISTRATION</b></p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders for one of six clients in the facility. (Client # 6)</p> <p>The findings include:</p> <p>1. Observation of the medication administration on December 17, 2009, at approximately 8:00 a.m., revealed the Licensed Practical Nurse #1 (LPN #1) administered Client #6, Baclofen 10 mg. one tablet by mouth.</p> <p>Review of Client #6's physician's order sheet (POS) dated December, 2009, on December 17, 2009, at approximately 12:15 p.m., revealed an order to administer Baclofen 10 mg. one tablet by mouth three times a day.</p> <p>Review of Client #6's Medication Administration Record (MAR) dated December 12, 2009, on</p>	W 368	<p><b>W368</b></p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>The assigned RN will conduct additional competency training and conduct routine observations of medication administration process. The LPN #2 was an agency staff and is no longer employed with the company. The Director of Nursing will review policy on medication administration and guidelines when a person is participating in community outing. The RN will continue to monitor medication administration routines and address concerns as they arise.</li> <li>Reference response to #1.</li> </ol>		1-7-10 ongoing

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W 368	<p>Continued From page 26</p> <p>December 17, 2009, at 12:25 p.m., revealed Baclofen 10 mg. one tablet by mouth at 1:00 p.m., was not administered because the client was out on an activity.</p> <p>During a face to face interview with LPN #2 on December 17, 2009, at approximately 2:30 p.m., it was acknowledged Baclofen 10 mg. one tablet by mouth at 1:00 p.m., was not administered as ordered.</p> <p>There was no documented evidence all drugs were administered in compliance with the physician's orders.</p> <p>2. Observation of the medication administration on December 17, 2009, at approximately 8:10 a.m., revealed LPN #1 administered Client #6, Cranberry Fruit 475 mg one capsule by mouth.</p> <p>Review of Client # 6's physician's order sheet (POS) dated December 2009, on December 17, 2009, at approximately 12:16 p.m., revealed an order to administer Cranberry Fruit 475 mg one capsule by mouth three times a day.</p> <p>Review of Client #6's MAR dated December 12, 2009, on December 17, 2009, at approximately 11:26 a.m., revealed Cranberry Fruit 475 mg one capsule by mouth at 12:00 p.m. was not administered because the client was out on an activity.</p> <p>During a face-to-face interview with LPN #2 on December 17, 2009, at approximately 2:35 p.m., it was acknowledged Cranberry Fruit 475 mg one capsule by mouth at 12:00 p.m., was not administered as ordered.</p>	W 368	<p>W371</p> <p>This Standard will be met as evidenced by:</p> <p>RN in coordination with the QMRP will reassess client #3 to determine if she has the functional abilities to participate in a self medication program. The RN will conduct training for all LPN staff on implementation and documentation of the program which will be monitored both by the QMRP and RN.</p>	12/29/09 original
W 371	463.460;(k)(4) DRUG ADMINISTRATION	W 371		

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W 371	<p>Continued From page 26</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for one of the three clients in the sample. (Client # 3)</p> <p>The finding includes:</p> <p>Observation of medication administration on December 17, 2009, at 7:15 a.m., revealed the Licensed Practical Nurse #1 (LPN #1) went into the kitchen and then poured water into a cup on the table and placed the cup of water into Client #3's hand. Further observation revealed LPN #1 held the medication cup to Client #3's mouth in order for the client to consume the medications with one (1) physical prompt.</p> <p>During a face-to-face interview with LPN #1 on December 17, 2009, at approximately 7:25 a.m., revealed Client #3 had a self-medication program that was to start on December 17, 2009, however there was not enough time during the morning medication administration to implement the self-medication program.</p> <p>Review of Client #3's self-medication assessment dated July 4, 2009, on December 17, 2009, at</p>	W 371			

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W 371	Continued From page 27 approximately 9:00 a.m., revealed Client #3 was approved to participate in a self-medication program to improve her self-medication skills. Review of Client #3's self-medication program dated December 17, 2009, on December 17, 2009, at approximately 9:10 a.m., indicated Client #3's self-medication program was as follows:  a. Gets a cup of water; b. Gets medication; c. Read out name of medication; d. Push medication inside of cup; e. Give medication pouch back to nurse; f. Take medication with water and g. Place cup inside trash can.  There was no evidence that the client was given the opportunity to fully participate in the self-medication program.	W 371		
W 381	483.46(X)(1) DRUG STORAGE AND RECORDKEEPING  The facility must store drugs under proper conditions of security.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security for six of six clients in the facility. (Client # 1, #2, #3, # 4, # 5 and #6)  The finding includes:  On December 17, 2009, at approximately 6:40 a.m., Licensed Practical Nurse #1 (LPN#1) was observed to leave Client #1's medication basket containing morning and evening medications unattended on the dining room table when she	W 381	W381 This Standard will be met as evidenced by:  RN will conduct regular medication administration observations of LPN staff. RN will re-train LPN's on expectations and policies and procedures related to safe storage and security.	12-19-09 ongoing

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W 381	Continued From page 28 administered medications in another room. Further observation revealed Client #3 was sitting at the dining room table and staff was going in and out of the dining area. In an interview with LPN#1 on December 17, 2009, at approximately 6:45 a.m., it was acknowledged Client #1's medication basket was left unattended on the dining room table.  There was no evidence that all drugs were stored under proper conditions of security.  [Note: On December 17, 2009, at approximately 6:46 a.m., LPN #1 immediately removed Client #1's medication basket from the dining table and placed the medication basket in a locked cabinet.]	W 381			
W 418	483.47(b)(4)(ii) CLIENT BEDROOMS  The facility must provide each client with a clean, comfortable mattress.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a comfortable mattress for one of the six clients residing in the facility was maintained. (Client #5)  The finding includes:  Observation of the environment was conducted with facility staff on December 18, 2009 at approximately 2:15 PM. An egg crate mattress on one of the beds was observed to have a large indentation at the center.  Interview with the facility staff during the	W 418	W418 This Standard will be met as evidenced by:  New mattresses have been obtained for all persons who are prescribed for use. The LPN and Facility Coordinator are responsible for monitoring the condition of the equipment. A master listing of all adaptive equipment will be developed for each person and monitored weekly by the Facility Coordinator. LPN/Facility Coordinator will provide training for all staff on adaptive equipment needs of each person.	12-28-09 07/2/09	

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W 418	Continued From page 29 environmental observation revealed that the bed belonged to Client #5. At the time of the survey, there was no evidence that Client #5 was provided with a mattress to ensure her comfort when lying in bed.	W 418		
W 426	483.4.70(d)(3) CLIENT BATHROOMS  The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.  This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure water temperatures did not exceed 110 degrees Fahrenheit at areas of the facility used by six of six clients (Clients #1, #2, #3, #4, #5, and #6)  The findings include:  On December 16, 2009 during hand washing at approximately 11:30 a.m., the surveyor noted the hot water temperature to be very warm. The clients were away from the facility at this time.  Interview with the facility coordinator (FC) on December 16, 2009 at 11:30 a.m. revealed that the hot water temperatures were monitored daily and recorded, and had not exceeded 110 degrees Fahrenheit.  On December 16, 2009, at 3:00 p.m., review of the hot water temperatures revealed the hot water in the facility exceeded 110 Fahrenheit as evidenced below:	W 426	W426  This Standard will be met as evidenced by:  The maintenance department will evaluate the hot water heater and take necessary actions, (install new hot water tank, install device to regulate water temperature) as needed to ensure that the water is properly regulated and maintained less than 110 degrees Fahrenheit. The Facility Coordinator will provide follow-up training to all staff on immediate notification to the maintenance department when situations arise as outlined in policy and procedure.	12-22-09 original

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W 426	Continued From page 30 a. Bathroom #2 - bath tub -120 degrees Fahrenheit (on side of building where hot water heater was located)  d. Bathroom #2 - hand sink -114 degrees Fahrenheit (on side of building where hot water heater was located)  The facility FC telephoned the maintenance supervisor at approximately 3:50 p.m. He arrived an hour later and adjusted the setting on the hot water. He remained on site until the hot water temperature did not exceed 110 degrees Fahrenheit at any of the faucets.  On December 16, 2009 at 4:20 p.m., measurement of the water temperatures in the aforementioned areas of the facility used by the clients revealed the water temperatures were 110 degrees Fahrenheit and 105 Fahrenheit respectively. There was no evidence however, that the facility had ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit at all times.	W 426		
W 440	483.47(l)(1) EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for two of the five shifts of duty reviewed.  The finding includes:  Interview with the Direct Care Staff and review of	W 440	W440 This Standard will be met as evidenced by:  The facility Coordinator has provided training for staff on fire drills and evacuation. The Facility Coordinator will monitor and track fire drills for each shift and coordinate drills and evacuation to maintain compliance with this standard as well as fire safety code standards. Routine audits will be conducted by the ADRS, DRS and other designated support staff.	12/22/09

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W 440	Continued From page 31 the staffing pattern on December 16, 2009 at 11:00 a.m. revealed the following staffing pattern:  Sunday - Saturday 6:30 a.m. - 6:00 p.m.; 6:00 p.m. - 6:30 a.m.; Monday-Friday 6:00 a.m. - 2:30 p.m.; 2:00 p.m. - 10:30 p.m.; and 10:30 a.m. to 6:30 a.m.  Review of the fire drill log revealed that the weekend shift for 6:30 a.m. - 6:00 p.m. and 6:00 p.m. - 3:30 a.m. from October 2008 to November 2009, failed to hold evacuation drills per shift per quarter. There was no evidence that the facility held fire drills at least quarterly for each shift of personnel.	W 440			
W 455	483.470(i)(1) INFECTION CONTROL  There must be an active program for the prevention, control, and investigation of infection and communicable diseases.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases for six of six clients residing at the home. (Clients #1, #2, #3, #4, #5 and Client #6)  The findings include:  1. On December 17, 2009, at approximately 6:30 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to wash her hands with soap and water prior to administering medications to Client #1.	W 455	W455 This Standard will be met as evidenced by:  Infection Control policies and procedures were recently updated and nursing staff have been re-trained on infection control. RN will implement disciplinary action moving forward for all staff who fails to adhere to the standards set forth. Director of Nursing in coordination with the Medical Director will develop and maintain an ongoing training/competency schedule to ensure that incoming and current staff adhere to infection control guidelines.	1/2/10	

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 8620 1ST STREET, NW WASHINGTON, DC 20012		
(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 455	<p>Continued From page 32</p> <p>However, LPN #1 touched the Medication Administration Records (MAR's), medication basket and then touched the rim of the medication cup Client #1 used to consume the medications.</p> <p>During a face to face interview with LPN #1 on December 17, 2009, at approximately 6:53 a.m., it was acknowledged after washing her hands her hands, she touched the MAR's, medication basket and then touched the rim of the medication cup Client #1 used for to consume medications.</p> <p>There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>2. On December 17, 2009, at approximately 6:50 a.m., LPN #1 was observed to wash her hands with soap and water prior to administering medications to Client #2. However, LPN #1 touched the Medication MAR's, medication basket and then touched the rim of the medication cup Client #2 used to consume the medications.</p> <p>During a face to face interview with LPN #1 on December 17, 2009, at approximately 6:54 a.m., it was acknowledged after washing her hands her hands, she touched the MAR's, medication basket and then touched the rim of the medication cup Client #2 used for to consume medications.</p> <p>There was no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p>	W 455			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6820 1ST STREET, NW WASHINGTON, DC 20012	

(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)	DATE COMPLETE DATE
1 000	INITIAL COMMENTS  A re-licensure survey was conducted from December 16, 2009 through December 18, 2009. A random sample of three residents was selected from a resident population of six females with various disabilities. Additionally, a focused review was conducted for two of the remaining three residents.  The findings of the survey were based on observations in the home and three day programs, interviews with staff in the home and day programs, as well as a review of the clinical, administrative, and habilitation records, including a review of the unusual incident/investigation reports.	1 000		
1 000	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation and interview the Group Home for Mentally Retarded Persons (GHMRP) failed to maintain the environment in a safe, clean, orderly, and attractive manner.  The findings include:  1. The GHMRP failed to maintain the interior environment safe, clean, orderly, and attractive as evidenced below:  A. Observation of the GHMRP environment was conducted on December 18, 2009, from 1:20	1 080	1090  3504.1  This Statute will be met as evidenced by:  All environmental concerns have been addressed. The Facility Coordinator will conduct a comprehensive environmental checklist at least once monthly. The Facility Coordinator will conduct routine environmental checks weekly and submit maintenance request for all needed repairs to ensure ongoing compliance with this statute.	1-7-10 01/08/10

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

PZMU11

1/18/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD05-0039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012
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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
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1 090	<p>Continued From page 1</p> <p>p.m. to 2:10 p.m. The observations revealed the following concerns:</p> <ol style="list-style-type: none"> <li>1. Soap scum was observed on the canvas underneath the shower gurney located in bathroom #2.</li> <li>2. Numerous deep cracks were observed in the foam pad on the shower gurney in bathroom #2.</li> <li>3. The faucet on the tub in bathroom #2 was observed not tightly secured to the wall.</li> <li>4. Caulking was partially missing where the tub was sealed to the wall in bathroom #2.</li> <li>5. A tile was observed to not be secured to the floor in front of Resident #3's bed. The corner was also broken from the tile.</li> <li>6. An egg crate mattress on Resident #5's bed was observed to have a large indentation at the center.</li> <li>7. The seat cover on the armchair in the bedroom of Residents #2 and #3 was heavily stained.</li> <li>8. Cabinet shelves were soiled in the following areas:             <ul style="list-style-type: none"> <li>(a) Cabinet underneath the sink in the laundry room;</li> <li>(b) Lower cabinet at the right side of the dishwasher; and</li> <li>(c) Lower cabinet at the left side of the refrigerator</li> </ul> </li> <li>9. An unsecured framed mirror was observed on the floor, leaning against the wall in the bedroom of Residents #4 and #5.</li> </ol>	1 090	<ol style="list-style-type: none"> <li>1. A new shower gurney has been ordered.</li> <li>2. Reference #1.</li> <li>3. The faucet on the tub in the bathroom has been repaired.</li> <li>4. Caulking in bathroom #2 has been completed.</li> <li>5. The tile has been replaced in resident #3's bedroom.</li> <li>6. New egg crates mattress have been ordered and received.</li> <li>7. The arm chair seat cover will be clean and or replaced.</li> <li>8. All cabinet shelves have been repaired and stains removed.</li> <li>9. The mirror will be secured or removed.</li> <li>10. The vinyl coverings on the bedrail will be replaced.</li> </ol> <p>8. Reference response to W426.</p>	1-7-10 ongoing
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6820 1ST STREET, NW WASHINGTON, DC 20012		
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
1090	Continued From page 2  10. The vinyl covering on the bedrail pads of Residents #5 and #6 was observed to be in a worn condition.  B. Based on observation, interview, and record review, the GHMRP failed to ensure water temperatures did not exceed 110 degrees Fahrenheit at areas of the GHMRP used by Residents #1, #2, #3, #4, #5, and #6.  During hand washing on December 16, 2009 at approximately 11:18 a.m., the surveyor noted the hot water temperature felt very warm. At the time of the observation, all residents were out of the group home.  Interview with the residential director on December 16, 2009 at 11:30 a.m. revealed that the hot water temperatures were monitored daily and recorded, and had not exceeded 110 degrees Fahrenheit.  On December 16, 2009 at 1:50 p.m., the hot water temperatures in the GHMRP were measured, and exceeded 110 Fahrenheit as evidenced below:  a. Bathroom #2 - bath tub -120 degrees Fahrenheit (on side of building where hot water heated was located)  d. Bathroom #2 - hand sink -114 degrees Fahrenheit (on side of building where hot water heated was located)  The residential director telephoned the maintenance supervisor at approximately 3:00 p.m. He arrived approximately one hour later and adjusted the setting on the hot water. He	1090		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED  12/16/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6820 1ST STREET, NW WASHINGTON, DC 20012	

(D4) 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)	(D5) COMPLETE DATE
1090	<p>Continued From page 3</p> <p>remained on site until the hot water temperature did not exceed 110 degrees Fahrenheit at any of the faucets.</p> <p>Measurement of the water temperature's on December 16, 2009 at 4:20 p.m. aforementioned areas of the GHMRP used by the residents, revealed the water temperatures were 110 degrees Fahrenheit and 105 Fahrenheit respectively. There was no evidence however, that the GHMRP had ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit at all times.</p> <p>II. The GHMRP failed to maintain the exterior environment as evidenced below:</p> <p>A. The light on the left side of the door leading to the patio, was not operable.</p> <p>B. A white, dust-like substance was observed on the roof, surrounding a pipe, which extended from the interior of the building. Interview with the residential director (RD) at 2:30 p.m., revealed that the pipe was part of the dryer vent system. Further interview with the RD revealed that the white, dust-like substance was lint from the dryer.</p> <p>Observation of the pipe leading from the dryer to the opening in the wall revealed dust/lint accumulation around the end of the pipe, where it entered the wall. Interview with the RD revealed that maintenance department services the dryer vent system to prevent the accumulation of lint in the duct system. At the time of the survey, however, there was no evidence an effective system for the management of lint had been implemented.</p>	1090	<p>II. The exterior of the home environment will be repaired and the dryer lint accumulation around the pipes will be removed. The maintenance director will implement a maintenance schedule to effectively address and prevent build up. The Facility Coordinator will conduct training on removal of lint following each dryer session.</p>	12/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD08-0033	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED  12/15/09
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6620 1ST STREET, NW WASHINGTON, DC 20012
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(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
I 135	Continued From page 4	I 135		
I 135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to hold evacuation drills at least quarterly for each shift of personnel, for two of the five shifts of duty reviewed.</p> <p>The finding includes: Interview with the Direct Care Staff and review of the staffing pattern on December 16, 2009 at 11:00 a.m. revealed the following staffing pattern: Sunday - Saturday 6:30 a.m. - 6:00 p.m.; 6:00 p.m. - 6:30 a.m.; Monday-Friday 8:00 a.m. - 2:30 p.m.; 2:00 p.m. - 10:30 p.m.; and 10:30 p.m. to 6:30 a.m.</p> <p>Review of the fire drill log revealed that the weekend shift for 6:30 a.m.-6:00 p.m. and 6:00 p.m. - 6:30 a.m. from October 2008 to November 2009, failed to hold evacuation drills per shift per quarter. There was no evidence that the facility held fire drills at least quarterly for each shift of personnel.</p>	I 135 I 135	<p>1135 3505.5</p> <p>This Statute will be met as evidenced by: Reference response to W440.</p>	1-5-10
I 208	<p>3609.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and</p>	I 208		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MFD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETE  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(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	
1206	Continued From page 5  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 staff interview and record review, the Group Home for the Mentally Retarded (GHMRF) failed to ensure that each employee had a health evaluation at least annually. (Staff #4, #7, #8, and #15)  The finding includes:  During the entrance conference with the Director of Residential Services on December 16, 2009 at 3:30 p.m., the surveyor requested that a current health certificate of each staff working in the group home be provided for review. On December 17, 2009 at 5:00 p.m., the review of the provided personnel records revealed that the health certificates provided for Staff #3, #8, #9 and #14 had expired. At 5:50 p.m., the surveyor notified the group home of this concern. An additional request for the current health certificates for the aforementioned staff was made on December 18, 2009, prior to the exit conference.  At the time of the survey, there was no evidence the health status of each employee working in the GHMRF were available.	1206	1206  3509.6  This Statute will be met as evidenced by:  The health certificates for staff #3, #8, #9 and #14 has been obtained. The Human Resources Department recently hired a staffing coordinator. The staffing coordinator in coordination with the HR Director will ensure that health certificates are updated prior to expiration.	1-4-10	
1222	3510.3 STAFF TRAINING  There shall be continuous, ongoing in-service	1222			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012	

(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)	END COMPLETE DATE
1222	<p>Continued From page 6</p> <p>training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure employees who work with clients, were trained on skills and competencies directed toward clients' health needs, for one of three residents in the sample (Resident #1) and two of two focus residents (Resident #4 and #5)</p> <p>The findings include:</p> <p>1. During an environmental observation on December 17, 2009, at approximately 10:00 a.m., Resident #1 had an unplugged oxygen canister with a covered nasal cannula beside her bed.</p> <p>During a face to face interview with LPN #2 on December 17, 2009, at approximately 10:30 a.m., it was revealed Resident #1 was administered oxygen two (2) liters at night. Further interview revealed that all staff had been trained on the client's oxygen therapy protocol.</p> <p>Review of Resident #1's physician's orders (POS) dated December 1, 2009, approximately 11:10 a.m., revealed an order for oxygen two (2) liters via nasal cannula if pulse oxygen is less than ninety (90%). Further review revealed oxygen two (2) liters via nasal cannula to keep oxygen sats (saturation) greater than eighty-eight (88%) whenever necessary and every night.</p> <p>Review of the facility's training records on December 17, 2009, at approximately 4:00 p.m. and on December 18, 2009, at approximately 10:20 a.m., revealed no evidence of Resident #1's training on oxygen therapy protocol.</p>	1222	<p>1222</p> <p>3510.3</p> <p>This Statute will be met as evidenced by:</p> <p>Reference responses to W192, W331, 381 and W336.</p>	1.18.10 on going

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD09-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6580 1ST STREET, NW WASHINGTON, DC 20012	

(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
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1222 Continued From page 7

During a face-to-face interview with the Registered Nurse on December 18, 2009, at approximately 10:30 a.m., it was acknowledged there was no sign-in sheets and agendas on oxygen therapy protocol in the training manuals.

There was no documented evidence the facility's staff was trained on skills and competencies directed toward the clients' health needs.

2. Review of Resident #4's hospital Summary Report dated July 13, 2009, on December 17, 2009, at approximately 11:05 a.m., revealed Resident #4 was admitted into the hospital on July 7, 2009, and discharged on July 13, 2009. Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. Resident #4's discharge diagnosis included acute or chronic anemia.

Review of Resident #4's Health Management Care Plan dated December 1, 2009, at approximately 2:05 p.m., revealed training was required to monitor for rectal bleeding.

Review of the facility's training records on December 17, 2009, at approximately 2:00 p.m. and on December 18, 2009, at approximately 2:20 p.m., revealed no training on monitoring for rectal bleeding.

During a face-to-face interview with the RN on December 18, 2009, at approximately 2:35 p.m., it was revealed staff was trained on monitoring of rectal bleeding. Further interview revealed there were no sign-in sheets and agendas on monitoring for rectal bleeding in the training manuals.

1222		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 8520 1ST STREET, NW WASHINGTON, DC 20012	

(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
122	Continued From page 8	122		
	<p>There was no documented evidence the facility's staff was trained on skills and competencies directed toward the clients' health needs.</p>			
	<p>3. Review of Resident #5's Medical Assessment dated May 1, 2009, on December 18, 2009, at approximately 11:22 a.m., revealed Resident #5 has diagnoses that include recurrent urinary tract infections (UTIs).</p>			
	<p>Review of urine culture and sensitivity laboratory studies revealed Resident #5 had urinary tract infections every month excluding May 2009, from December 22, 2008 to October 1, 2009.</p>			
	<p>Review of Resident #5's medical record on December 18, 2009, at approximately 3:30 p.m., revealed a Health Management Care Plan (HMCP) dated April 28, 2009, that documented recommendations including the following: to maintain regular one to two hourly diaper changes; provide water and soap skin cleansing with each diaper change, monitor vulva area for signs of infection (redness, rashes and swelling).</p>			
	<p>Review of the facility's training records on December 18, 2009, at approximately 3:45 p.m., revealed the only documented staff training on incontinence/peri-care was on October 13, 2009.</p>			
	<p>During a face-to-face interview with the consulting Qualified Mental Retardation Professional (QMRP) on December 18, 2009, at approximately 3:58 p.m., it was acknowledged additional training was needed in the area of incontinence/peri-care.</p>			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HPD09-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6529 1ST STREET, NW WASHINGTON, DC 20012		
(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	
1222	<p>Continued From page 9</p> <p>There was no documented evidence of continuing training enabling the employees to perform their duties effectively, efficiently, and competently.</p> <p>4. Review of Resident #1's Medical Assessment dated November 5, 2009, on December 17, 2009, at approximately 1:00 p.m., revealed Resident #1 had diagnoses that include Acute Cystitis, and a history of recurrent Urinary Tract Infections (UTIs).</p> <p>Review of urine culture and sensitivity laboratory studies and review of physician orders from December 2008 through December 2009 revealed Resident #1 had urinary tract infections that required treatment in December 2008, February 2009 x 2, April 2009, June 2009, October 2009, and December 2009.</p> <p>Review of Resident #1's medical record on December 16, 2009, at approximately 2:30 p.m., revealed a Health Management Care Plan (HMCP) dated October 30, 2009, and reviewed on December 12, 2009, revealed a recommendation to encourage adequate daily fluid intake, monitor for signs of UTI (fever, highly concentrated urine, decreased urine output), and monitor response to treatment. Further review of the medical record reveal urology consults dated August 24, 2009, June 24, 2009, and February 13, 2009, recommending increased fluid intake, change often, good genital hygiene and toileting regime.</p> <p>Review of the facility's training records on December 18, 2009, at approximately 3:45p.m., revealed the only documented staff training on incontinence/perf-care was on October 13, 2009.</p>	1222			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(D1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HPD03-0033	(D2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(D3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6630 1ST STREET, NW WASHINGTON, DC 20012	

(D4) 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)	(D5) COMPLETE DATE
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1222 Continued From page 10  
 During a face-to-face interview with the Consulting Mental Retardation Professional (CMRP) on December 18, 2009, at approximately 3:58 p.m., it was acknowledged additional training was needed in the area of incontinence/peri-care.  
 There was no documented evidence of continuing training enabling the employees to perform their duties effectively, efficiently, and competently.

1222

1223 3510.4 STAFF TRAINING  
 Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.  
 This Statute is not met as evidenced by:  
 Based on interview and record review the facility failed to ensure the training program agenda and record of staff participation was maintained in and available for review by regulatory agencies for one of three clients in the sample. (Resident #1) and one of two focus residents. (Resident #4)  
 The findings include:  
 1. During an environmental observation on December 17, 2009, at approximately 10:00a.m., Resident #1 had an unplugged oxygen cannister with a covered nasal cannula beside her bed.  
 During a face to face interview with LPN #2 on December 17, 2009, at approximately 10:30a.m., it was revealed Resident #1 was administered oxygen two (2) liters at night. Further interview revealed that all staff had been trained on oxygen therapy protocol.

1223  
 3510.4  
 This Statute will be met as evidenced by:  
 Reference response to W 192, W331, W336, and W381.

1-7-10  
original

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HPD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 223	<p>Continued From page 11</p> <p>Review of Resident #1's physician's orders (POS) dated December 1, 2009, approximately 11:10 a.m., revealed oxygen two (2) liters via nasal cannula if pulse oxygen is less than ninety (90%). Further review revealed oxygen two (2) liters via nasal cannula to keep oxygen sats (saturation) greater than eighty-eight (88%) whenever necessary and every night.</p> <p>Review of the facility's training records on December 17, 2009, at approximately 4:00 p.m. and on December 18, 2009, at approximately 10:20 a.m., revealed no evidence of training on oxygen therapy protocol.</p> <p>During a face to face interview with the Registered Nurse (RN) on December 18, 2009, at approximately 10:30 a.m., it was acknowledged there was no sign-in sheets and agendas on oxygen therapy protocol in the training manuals.</p> <p>There was no documented evidence the facility's staff was trained on skills and competencies directed toward the clients' health needs.</p> <p>2. Review of Resident #4's hospital Summary Report dated July 13, 2009, on December 17, 2009, at approximately 11:05 a.m., revealed Resident #4 was admitted to the hospital on July 7, 2009, and discharged on July 13, 2009. Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. Resident #4's discharge diagnosis included acute or chronic anemia.</p> <p>Review of Resident #4's Health Management Care Plan dated December 1, 2009, at approximately 2:05 p.m., revealed training was required to monitor for rectal bleeding.</p>	1 223		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
	NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 18T STREET, NW WASHINGTON, DC 20012

(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
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1223	Continued From page 12  Review of the facility's training records on December 17, 2009, at approximately 2:00 p.m. and on December 18, 2009, at approximately 2:20 p.m., revealed no training on monitoring for rectal bleeding.  During a face to face interview with the RN on December 18, 2009, at approximately 2:35 p.m., it was revealed staff had been trained on the monitoring of rectal bleeding. Further interview revealed there were no sign-in sheets and agendas on monitoring for rectal bleeding in the training manuals.  There was no documented evidence the facility's staff was trained on skills and competencies directed toward the resident's health needs.	1223		
1226	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 six of six residents residing at the home. (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6)  The findings include:  1. On December 17, 2009, at approximately 8:30 a.m., Licensed Practical Nurse #1 (LPN #1) was	1226	1226  3510.5(c)  This Statute will be met as evidenced by:  Reference responses to W455.	1/4/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HPD03-0033	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012	

(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
1226	<p>Continued From page 13</p> <p>observed to wash her hands with soap and water prior to administering medications to Resident #1. However, LPN #1 touched the Medication Administration Records (MAR's), medication basket and then touched the rim of the medication cup Resident #1 used to consume the medications.</p> <p>During a face to face interview with LPN #1 on December 17, 2009, at approximately 6:53 a.m., it was acknowledged after washing her hands her hands, she touched the MAR's, medication basket and then touched the rim of the medication cup Resident #1 used for to consume medications.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>2. On December 17, 2009, at approximately 6:50 a.m., LPN #1 was observed to wash her hands with soap and water prior to administering medications to Resident #2. However, LPN #1 touched the Medication MAR's, medication basket and then touched the rim of the medication cup Resident #2 used to consume the medications.</p> <p>During a face to face interview with LPN #1 on December 17, 2009, at approximately 6:54 a.m., it was acknowledged after washing her hands her hands, she touched the MAR's, medication basket and then touched the rim of the medication cup Resident #2 used for to consume medications.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p>	1226		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(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 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each staff was trained to implement emergency procedures for six of six residents living in the group home for mentally retarded persons (GHMRP). (Residents #1, #2, #3, #4, #5 and #6).</p> <p>The findings include:</p> <p>During the entrance conference on December 16, 2009, at approximately 3:30 p.m., the director of residential services was requested to provide the training records for all staff and consultants working in the GHMRP.</p> <p>On December 17, 2009 at 5:00 p.m., the review of the provided training records revealed that the certifications in cardiopulmonary resuscitation (CPR) and first aid were not available for one of fourteen (14) staff, Staff #8. The administrative office was notified of this concern at that time.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on December 18, 2009 at 2:35 p.m., revealed the s record of current CPR and first aid certification was not available for Staff #8. At the time of the survey, there was no evidence that the GHMRP had ensure that each staff working in the home maintained current</p>	I 227	<p>1227</p> <p>3510.5 (d)</p> <p><b>This Statute will be met as evidenced by:</b></p> <p>Staff #8 has been scheduled for CPR/First Aid. The Facility Coordinator will monitor the status of all training records monthly.</p> <p>The Training Coordinator will continue to schedule and coordinate required staff training and complete tracking form of all required training.. Staff determine not in compliance will be removed from the schedule if compliance is not obtain as directed.</p>	12.30.09 ongoing

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(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 227	Continued From page 15 certification in emergency procedures.	( 227		
I 291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all persons making entries into the clients' records were dated and signed, for two of the three residents in the sample. (Resident #1 and Resident #3) and one of two focused residents. (Resident #4)</p> <p>The findings include:</p> <p>1. Review of Resident #3's medical record on December 17, 2009, at approximately 2:30 p.m., revealed a nursing quarterly assessment completed October 2009 with no signature. The observation was brought to the attention of the facility nurses at approximately 10:00 a.m. who acknowledged that the nursing quarterly assessment was not signed by the author.</p> <p>2. Review of Resident #1's medical record on December 17, 2009 at approximately 2:15 p.m., revealed several documents that were not signed or dated as evidenced below:</p> <p>a. Record review revealed a hand written physician order dated January 26, 2009 indicating the following: "Continue Pulmicort nebs twice a day, Albuterol nebs q 6h x 48 hours then as needed (please give her a neb treatment when she wheezes), Oxygen 2L NE when O2 sats &lt; 88%, D/C combivent her Inhaler." Further review revealed the transcriber failed to reflect the time, the manner received (via prescription or</p>	I 291	<p>1291</p> <p>3514.2</p> <p>This Statute will be met as evidenced by:</p> <p>1. Reference response to W336.</p> <p>2., 3., and #4 reference responses to W114, W192, W214, W336, W368 and W371.</p>	1.7.10 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012	

(C4) 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)	(C5) COMPLETE DATE
1291	<p>Continued From page 16</p> <p>telephone order) and by whom.</p> <p>b. Review of Resident #1's medical record evidenced a hand written order prescribing "Lasix 10 mg po give 2 tabs for 5 days, then continue with tab QD." There was no date or time indicated, or prescriber indicated on the order. In addition, the physician had failed to sign the order.</p> <p>During a face-to-face interview on December 17, 2009 at approximately 3:00 p.m., the LPN acknowledged the aforementioned orders had not been dated and signed off by the author and by the primary care physician.</p> <p>c. Resident #1's Abnormal Involuntary Movement Scale (AIMS) assessment dated February 1, 2009 failed to evidence the signature of the author that completed the assessment.</p> <p>3. Review of Resident #4's medical record on December 17, 2009, at 2:00 p.m., revealed a Health Management Care Plan (HMCP) dated December 1, 2009, that was not dated and signed off by the author.</p> <p>During a face-to-face interview on December 17, 2009, at approximately 2:05 p.m., the RN acknowledged the HMCP had not been dated and signed off by the author.</p> <p>4. Review of Resident #4's medical record on December 17, 2009 at 2:10 p.m., revealed a Health Service Summary (HSS) dated December 1, 2009, that was not dated and signed off by the author. Further review revealed the author had typed in their name.</p>	1291		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012	

(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
1291	Continued From page 17  During a face-to-face interview on December 17, 2009 at approximately 2:20 p.m., the RN acknowledged the HSS had not been dated and signed off by the author.  There was no documented evidence the HSS was dated and signed off by the author.	1291	1401 3520.3  This Statute will be met as evidenced by:	
1401	<b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b>  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.  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure services were provided in accordance with the needs of six of six residents residing in the facility. (Residents # 1, #2, #3, #4, #5 and #6)  The findings include:  1. The primary care physician failed to clarify Resident #5's hydration order as evidenced below.  On December 16, 2009, at 5:20 p.m., Resident #5 was observed to consume approximately 96% of her solids and 16 oz of fluids during the dinner meal. During the medication administration on December 17, 2009, at 8:15 a.m., the client was observed to take her medications by mouth with	1401	1. The primary care physician will clarify the order for client #5. Reference response to W114. 2. The facility nursing staff will demonstrate timely nursing follow-up as evidenced by: See response to W192, W322 and W331. 3. The facility nursing services will ensure that each person's health status is recorded on the MAR. Reference responses to W322, and W336. 4. Reference response to W331, W104, W114. 5. Reference responses to W331 and W192. 6. Cross reference response to W192. 7. Cross reference to W368 8. Cross reference to W371. 9. Cross reference to W381. 10. Cross reference to W455. 11. Reference response to W114, W192, W214.	1-17-10 Original

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6430 1ST STREET, NW WASHINGTON, DC 20012	

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1401	<p>Continued From page 18</p> <p>apple juice.</p> <p>Interview with the LPN on December 18, 2009, at 1:32 p.m. revealed that Resident #5 received all food, supplement, medications and fluids by mouth, and no longer required her water to be administered via Gtube. The LPN indicated that the client should receive 12 cups of fluid daily.</p> <p>According to the annual nutritional assessment dated April 29, 2009, the client needed a minimum of 1830 cc fluid/day (30 cc/kg x 61 kg body weight). The review of the current physician's orders dated December 1, 2009, revealed a continuing order (initially dated 8/8/08) documented the following instructions for water: "Flush with 30 ml before and after each medication and between medications". The nurse initialed for each shift (8:00 a.m. - 4:00 p.m.; 4:00 p.m. - 12:00 a.m.; 12:00 a.m. - 8:00 a.m.).</p> <p>At the time of the survey, there was no evidence the PCP had addressed the nutritionist fluid recommendations.</p> <p>2. The facility's nursing services failed to ensure timely medical follow-ups as recommended by the urologist.</p> <p>Review of Resident #5's urology consult dated July 27, 2009, on December 18, 2009, at approximately 11:26 a.m., revealed a recommendation for Resident #5 to have follow-up appointment in three (3) months.</p> <p>Review of Resident #5's medical records on December 18, 2009, at approximately 11:57 a.m., revealed no follow-up urology appointment in the medical record.</p>	1401		

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6620 1ST STREET, NW WASHINGTON, DC 20012	

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1401	<p>Continued From page 19</p> <p>During a face to face interview with the RN on December 18, 2009, at approximately 3:00 p.m., it was revealed the client had gone to the urologist on October 30, 2009, however acknowledged the results of the urology consult was not in the medical record.</p> <p>3. The facility's nursing services failed to ensure the resident's health status was recorded on the Medication Administration Record (MAR).</p> <p>Observation of medication administration on December 17, 2009, at approximately 7:30 a.m., revealed Licensed Practical Nurse #1 (LPN #1) administered Carvedilol 3.125 mg one tablet by mouth to Resident #4.</p> <p>Review of the December, 2009, Medication Administration Record (MAR) on December 17, 2009, at approximately 12:00 p.m., revealed Resident #4's apical pulse was recorded each time the medication was administered except on December 17, 2009, at 7:00 a.m.</p> <p>During a face to face interview with LPN #2 on December 17, 2009, at approximately 1:05 p.m., it was acknowledged Resident #4's apical pulse was not recorded on the MAR for the aforementioned date.</p> <p>4. The facility's nursing services failed to ensure the results of medical studies were recorded in each client's medical record.</p> <p>a. Review of Resident #4's hospital Summary Report dated July 13, 2009, on December 17, 2009, at approximately 11:05 a.m., revealed Resident #4 was admitted to the hospital on July 7, 2009, and discharged on July 13, 2009.</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED  12/18/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012
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(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
1401	<p>Continued From page 20</p> <p>Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. An esophagogastroduodenoscopy (EGD) was recommended to be performed while the resident was in the hospital.</p> <p>Review of Resident #4's medical records on December 17, 2009, at approximately 3:25 p.m., revealed the results of the EGD was not in the medical record.</p> <p>During face to face interviews with the RN and Consulting Qualified Mental Retardation Professional (CQMRP) on December 17, 2009, at approximately 4:10 p.m., and on December 18, 2009, at approximately 2:35 p.m., it was acknowledged the results of the EGD was not in the medical record. Further interview revealed the attending physician at the hospital was left a voice mail message in regarding obtaining the results of the EGD.</p> <p>b. Review of Resident #4's hospital Summary Report dated July 13, 2009, on December 17, 2009, at approximately 11:05 a.m., revealed Resident #4 was admitted to the hospital on July 7, 2009, and discharged on July 13, 2009. Further review revealed the client had an admission hematocrit of 29 and an acute drop to 22 while in the hospital. A colonoscopy was recommended to be performed while the resident was in the hospital.</p> <p>Review of Resident #4's medical records on December 17, 2009, at approximately 3:25 p.m., revealed the results of the colonoscopy was not in the medical record.</p> <p>During face to face interviews with the RN and</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HPD08-0033	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(C3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(K4) 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)	(C5) COMPLETE DATE	
1401	<p>Continued From page 21</p> <p>Consulting Qualified Mental Retardation Professional on December 17, 2009, at approximately 4:10 p.m., and on December 18, 2009, at approximately 2:35 p.m., it was acknowledged the results of the colonoscopy was not in the medical record. Further interview revealed the attending physician at the hospital was left a voice mail message in regarding obtaining the results of the colonoscopy.</p> <p>6. The facility's nursing services failed to ensure timely laboratory studies were performed as recommended by the urologist.</p> <p>a. Review of Resident #5's urology consult dated July 27, 2009, on December 18, 2009, at approximately 11:26 a.m., revealed a recommendation for Resident #5 to have a repeat C&amp;S (urine culture and sensitivity) study.</p> <p>Review of Resident #5's laboratory studies on December 18, 2009, at approximately 11:55 a.m., revealed a urine culture and sensitivity study dated August 11, 2009 and the urine contained Escherichia Coll (E. Coll) and the client was prescribed Macrobid 100 mg twice a day for ten (10) days. Further review of urine culture and sensitivity laboratory studies revealed the client had urinary tract infections every month excluding May 2009, from December 22, 2009 to October 1, 2009</p> <p>During a face-to-face interview with the RN on December 17, 2009, at approximately 4:05 p.m., it was acknowledged the laboratory study was not performed timely.</p> <p>b. Review of Resident #5's Medical Assessment dated May 1, 2009, on December 18, 2009, at approximately 11:20 a.m., revealed a</p>	1401			

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 8620 19T STREET, NW WASHINGTON, DC 20012
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1401	<p>Continued From page 22</p> <p>recommendation for Resident #5 to have urine culture and sensitivity laboratory studies every three months. Further review revealed the resident has diagnoses that include recurrent urinary tract infections (UTIs).</p> <p>Review of Resident #5's laboratory studies on December 18, 2009, at approximately 11:57 a.m., revealed a urine culture and sensitivity study was collected and recorded in the medical record for August 2009 and was positive for Escherichia Coli (E. Coli). Further review of the laboratory studies revealed a urine culture and sensitivity study was not collected and recorded in the medical record three months later in the month of November 2009.</p> <p>Review of urine culture and sensitivity laboratory studies revealed Resident #5 had urinary tract infections every month excluding May 2009, from December 22, 2008 to October 1, 2009.</p> <p>During a face-to-face interview with the RN on December 18, 2009, at approximately 3:58 p.m., it was acknowledged the laboratory studies were not performed timely.</p> <p>6. Cross Refer to W 192. The facility's nursing services failed to ensure employees who work with the residents were trained on skills and competencies directed toward residents' health needs.</p> <p>7. Cross Refer to W 368. The facility's nursing services failed to ensure that all drugs were administered in compliance with the physician's orders.</p> <p>8. Cross Refer to W371. The facility's nursing services failed to implement an effective system</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0033	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 18T STREET, NW WASHINGTON, DC 20012		
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE	
1401	<p>Continued From page 23</p> <p>to ensure Resident #3 participated in a self-medication training program.</p> <p>9. Cross Refer to W381. The facility's nursing services failed to store drugs under proper conditions of security.</p> <p>10. Cross Refer to W455. The facility's nursing services failed to provide an active program for the prevention and control of infection and communicable diseases.</p> <p>11. The facility failed to ensure a comprehensive functional assessment of specific developmental and behavioral management needs were completed for Resident #1 and #3 as evidenced below:</p> <p>a. Observation of the morning medication administration on December 17, 2009, beginning at 6:35 a.m. revealed Resident #1 received medications including Nalrexone. Interview with the medication nurse during the medication administration, revealed the aforementioned medication was used to address the resident's behaviors.</p> <p>Review of the Medication Administration Record (MAR) on December 17, 2009, revealed a Physician's Order dated December 1, 2009. Continued review of the order also revealed Resident #1 was prescribed Zyprexa at nighttime to address behaviors. Interview with Qualified Mental Retardation Professional (QMRP) on December 16, 2009, at 12 noon verified that Resident #1's medication was used to control behaviors in conjunction with a Behavior Support Plan (BSP).</p> <p>Continued interview with the QMRP was</p>	1401			

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6620 1ST STREET, NW WASHINGTON, DC 20012		
(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)	DATE COMPLETE
I 401	Continued From page 24  conducted to ascertain if Resident #1 had a comprehensive psychiatric assessment to justify the use of the behavior modification drugs and her corresponding psychiatric diagnoses (Schizophrenia). At the time of the survey, the facility failed to provide evidence that Resident #1 received a comprehensive psychiatric assessment.  b. Observation of the morning medication administration on December 17, 2009, beginning at 8:35 a.m., revealed Resident #3 received medications including Perphenazine. Interview with the medication nurse during the medication administration, revealed the aforementioned medication was used to address the resident's behaviors.  Review of the Medication Administration Record (MAR) on December 17, 2009, revealed a Physician's Order dated December 1, 2009. Continued review of the order revealed Resident #3 was prescribed Lexapro to address depression. Interview with Qualified Mental Retardation Professional (QMRP) on December 18, 2009, at 12:30 p.m. verified that Resident #3's medication was used to control behaviors in conjunction with a Behavior Support Plan (BSP).  Continued interview with the QMRP was conducted to ascertain if Resident #3 had a comprehensive psychiatric assessment to justify the use of the behavior modification drugs and her corresponding psychiatric diagnoses (Intermittent Explosive Disorder, Depression). At the time of the survey, the facility failed to provide evidence that Resident #1 received a comprehensive psychiatric assessment.	I 401		

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 8820 1ST STREET, NW WASHINGTON, DC 20012		
(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
1422	Continued From page 26	1422		
1422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to provide training and assistance to each resident in accordance with the resident's Individual Habilitation Plan for two of three residents in the sample. (Residents #2 and #3).</p> <p>The finding includes:</p> <ol style="list-style-type: none"> <li>1. Cross refer to W371. The GHMRP failed to implement an effective system to ensure that each resident participated in a self-medication training program, for Resident # 3.</li> <li>2. The GHMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for Resident #2.                     <ol style="list-style-type: none"> <li>a. The GHMRP failed to ensure that Resident #2's program goal designed to improve her standing tolerance was implemented as written, as evidenced below:</li> </ol> </li> </ol> <p>Interview with staff on December 17, 2009 at 11:20 a.m., revealed that staff supervised Resident #2 in standing up for 5 minutes every hour, when she is awake to improve her tolerance of standing. Staff indicated that the resident's standing was incorporated during activities of daily living and at other times during the day as recommended by the physical therapist. According to staff, the resident's</p>	1422 1422	<p>1422 3521.3 This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Cross reference response to W371.</li> <li>2. Cross reference response to W249.</li> </ol>	1/18/10 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NFD03-0089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  12/18/2009
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 8820 1ST STREET, NW WASHINGTON, DC 20012		
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1422	<p>Continued From page 26</p> <p>standing should be documented in her program book. Interview with the Qualified Mental Retardation Professional (QMRP) on December 18, 2009, 1:10 p.m. revealed that the resident's participation in the objective was being monitored by the physical therapist.</p> <p>Record review on December 17, 2009 at 11:50 a.m. revealed on March 6, 2009, the interdisciplinary team (IDT) recommended a goal (March 2009 to March 2010), to "Improve the resident's tolerance of standing." According to the corresponding objective, the resident "will stand for at least 5 minutes every 30 minutes that she is awake at 100% accuracy for one month." Subsequent review of the program data (for September, October, November and December 2009) at that time of the survey confirmed staff statements that the objective was implemented hourly. At the time of the survey, there was no evidence that the standing for five minutes had been implemented every thirty minutes as recommended by the IDT.</p> <p>b. The GHMRP failed to ensure that Resident #2's program goal designed to improve her trunk range of motion was implemented at the recommended frequency as evidenced below:</p> <p>Interview with staff on December 17, 2009 at 11:20 a.m. revealed that Resident #2 was supposed to lie prone in her bed for 10 minutes. Further interview with staff revealed the number of minutes that the resident was able to remain in the prone position should be documented in the morning and in the evening. Staff indicated that the resident usually did not tolerate this position for more than five minutes.</p> <p>Review of the IPP revealed the IDT</p>	1422			

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
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I 422	Continued From page 27  recommended a goal (March 2009 to March 2010) a goal to improve Resident #2's trunk range of motion. The objective stated the resident "will tolerate the prone position for 10 minutes at 100% accuracy for 6 months." In August 2009, programming of this objective was temporarily placed on hold due to an injury Resident #2 sustained to her shoulder. Review of the Physical Therapy assessment on September 24, 2009, however revealed a recommendation that the objective be resumed. Record review revealed the objective was not resumed until November 2009. At the time of the survey, there was no evidence that Resident #1's goal to improve her trunk range of motion was implemented as recommended.  2. The GHMRP failed to ensure data was collected in a manner to accurately measure progress on the individual program plan (IPP) objectives for Resident #2).  a. Cross refer to W249.1. The GHMRP failed to collect data in measurable terms for Resident #2's training objective designed to improve her standing tolerance as evidenced below:  Interview with the direct care staff on December 17, 2009, at 11:20 a.m. revealed that the staff supervised Resident #2 in standing up for 5 minutes every hour when she is awake to improve her tolerance of standing.  Record review revealed a goal to improve Resident #2's standing tolerance. According to the IPP objective, the resident "will stand for at least 5 minutes every 30 minutes that she is awake at 100% accuracy for one month." Although the IPP stated that the resident should stand for 5 minutes every 30 minutes, the data	I 422	1472 This Statute will be met as evidenced by:  Reference response to W371.	1.7.10 ongang

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
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1422	Continued From page 28  collection form stated the program frequency was every hour. The times typed on the form were hourly (example: 6:00 a.m., 7:00 a.m...to 8:00 p.m.) . There was no evidence that data was collected in a manner to determine if the resident had stood or five minutes every 30 minutes.  b. Interview with the direct care staff on December 17, 2009 at 11:20 a.m., revealed Resident #2 had a goal to improve her trunk range of motion. According to the objective, two times a day, the resident "will tolerate the prone position for 10 minutes at 100% accuracy for 6 months." Interview with the staff on December 17, 2009 at approximately 12:10 p.m., the program was implemented in the morning and the evening, however at times it was difficult for the resident to remain in the prone position.  On December 18, 2009 at 9:50 a.m., the review of program data revealed the resident had been able to tolerate the prone position for 5 minutes 32/34 provided opportunities during November 2009. Data collection for December 2009 however revealed the resident had tolerated the prone position for 0 minutes on 17/20 provided opportunities for the first 10 days of the month. There was no documentation on the form concerning possible reasons why the resident did not participate in the training. Although data collected for December 14, 15, and 16, 2009 indicated that the resident tolerated 10 minutes of prone positioning in the p.m., no data was available for the morning on these dates. Additionally, no data was available after December 16, 2009 for the morning or evening.	1422		
1472	3522.3 MEDICATIONS  The physician who identifies the	1472	1472	

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1472	<p>Continued From page 29</p> <p>self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation.</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for one of the three clients in the sample. (Resident # 3)</p> <p>The finding includes:</p> <p>Observation of medication administration on December 17, 2009, at 7:15 a.m., revealed the Licensed Practical Nurse #1 (LPN #1) went into the kitchen and then poured water into a cup on the table and placed the cup of water into Resident #3's hand. Further observation revealed LPN #1 held the medication cup to Resident #3's mouth in order for the client to consume the medications with one (1) physical prompt.</p> <p>During a face-to-face interview with LPN #1 on December 17, 2009, at approximately 7:25 a.m., revealed Resident #3 had a self-medication program that was to start on December 17, 2009, however there was not enough time during the morning medication administration to implement the self-medication program.</p> <p>Review of Resident #3's self-medication assessment dated July 4, 2009, on December 17, 2009, at approximately 9:00 a.m., revealed Resident #3 was approved to participate in a self-medication program to improve her self-medication skills. Review of Resident #3's self-medication program dated December 17, 2009, on December 17, 2009, at approximately</p>	1472	<p>This Statute will be met as evidenced by:</p> <p>Reference responses to W192, 322, 371.</p> <p>Self-medication program is currently being implemented as outlined for client #3. RN/QMRP will continue to monitor to ensure ongoing compliance with this standard.</p>	12-30-09 ongoing

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012
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1472	<p>Continued From page 30</p> <p>9:10 a.m., indicated Resident #3's self-medication program was as follows:</p> <ul style="list-style-type: none"> <li>a. Gets a cup of water;</li> <li>b. Gets medication;</li> <li>c. Read out name of medication;</li> <li>d. Punch medication inside of cup;</li> <li>e. Give medication pouch back to nurse;</li> <li>f. Take medication with water and</li> <li>g. Place cup inside trash can.</li> </ul> <p>There was no evidence that the resident was given the opportunity to fully participate in the self-medication program.</p>	1472		