

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
--	---

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--	--	----------------------

W 000 INITIAL COMMENTS

A recertification survey was conducted on December 14, 2010, through December 16, 2010. Due to systemic deficient practices identified during the August 2010 investigation, the State Agency determined that the full survey process would be utilized. A random sample of four clients was selected from a residential population of seven females with various degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and one day program, interviews with staff in the home and one day program, as well as a review of the clinical, administrative, and habilitative records, including a review of the unusual incident reports.

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, interview, and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure each client's active treatment program was integrated, coordinated and monitored by a qualified mental retardation professional for five of seven clients residing in the facility. (Clients #1, 3, #4, #6, and #7)

The finding includes:

1. Cross Refer to W436. The QMRP failed to ensure that clients' prescribed adaptive

W 000

W 159

Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

2-3-11

1. See response to W436.

2/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marsha H. Thompson</i>	TITLE <i>Chief Operating Officer</i>	(X6) DATE 1/3/11
--	---	---------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4964 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--	--	----------------------

W 159 Continued From page 1
equipment (i.e. wheelchairs, chest harness, lap trays, etc...) were maintained in good condition, for Clients #1, #4, #6, and #7.

2. Cross refer to W252. The QMRP failed to ensure that data was consistently and accurately maintained to monitor Client #3's tolerance of her wrist splints.

W 252 483.440(e)(1) PROGRAM DOCUMENTATION

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective, for one of four clients in the sample. (Client #3)

The finding includes:

The facility failed to ensure that data required to monitor Client #3's tolerance of her wrist splints was consistently and accurately maintained.

Observation in Client #3's bedroom on December 14, 2010, at 3:30 p.m. revealed bilateral wrist splints. Later that day, interview with staff at 4:57 p.m. revealed that the client wore them at night while she was sleeping.

Interview with the Licensed Practical Nurse (LPN) on December 15, 2010, at 2:05 p.m. revealed the client had a treatment order to "wear resting hand

W 159

2. See response o W252.

W 252

The QMRP will retrain all staff, including LPN staff, on use of the splints and documentation of usage. The QMRP will provide data and reports to the clinician to ensure that he has the information needed to make appropriate clinical decisions. The Director of Residential Services (DRS) will monitor for three months to ensure compliance.

2/3/11

2/3/11

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 252 Continued From page 2
splints to both hands from 9:00 p.m. to 5:00 a.m." The nurse indicated that the client was to gradually increase the amount of time she tolerated the splints up to 8 hours. Continued discussion with the LPN at approximately 2:50 p.m. indicated staff should monitor the client's tolerance of the wrist splints and document it on the data collection form. During this discussion, the qualified mental retardation professional (QMRP) stated that staff reported that the client hollered at times and did not want to wear the wrist splints.

Record review on December 15, 2010, at 2:05 p.m. revealed a physical therapy (PT) goal dated September 2010 which documented that Client #3 will tolerate wearing wrist resting splints. According to the objective, the client "will wear the resting splints from 9:00 p.m. to 5:00 a.m."

Further review of the active treatment documentation form revealed that daily staff should "document the number of hours the client wore the brace," or if there was "no response." On December 15, 2010, at 3:10 p.m., the data collection revealed the client wore the braces eight days in August 2010, five days in September 2010, and five days in October 2010.

At the time of the survey, the facility failed to provide evidence that y ensured data was collected in a manner to accurately monitor the client's tolerance of her splints.

W 252

W 356 483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT

The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental

W 356

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 356 Continued From page 3 health.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure timely comprehensive treatment services for the maintenance of dental health, for one of the four clients in the sample. (Client #1)

The finding includes:

On December 14, 2010, at 12:05 p.m., observations conducted at the day program revealed Client #1's was observed to have a heavy build up plaque and discoloration (yellowish) around her teeth. Review of Client #1's medical record on December 15, 2010, at approximately 11:10 a.m., revealed a dental consultation dated March 2, 2010. The dentist noted "moderate calculus deposit. Patient needs scaling, will submit Pre-authorization for approval..." Please call if we have not contacted you in two months. Further record review revealed the client went back to the dentist on July 19, 2010. The dental consultation noted, "Patient has very poor oral hygiene. Large deposits of plaque and calculus present on all teeth surfaces. Diagnoses: Halitosis/Periodontitis. Full mouth scaling is indicated. Preauthorization request will be submitted..."

Interview with the qualified mental retardation professional (QMRP) on December 16, 2010, at approximately 1:20 p.m., revealed that the client had not returned back to the dental office since July 19, 2010. Further interview with the QMRP revealed that Client #1 had not received any dental treatment since May 11, 2009, over 9

W 356

The QMRP and RN will ensure that when a dental consult recommends a treatment that requires pre-authorization, the Nurse will coordinate with the dental office to ensure that the pre-authorization request is submitted at the time the recommendation is made, and that an appointment is secured to coincide with the expected date of the approval so that the approval does not expire before the appointment occurs. The Director of Nursing (DN) and the DRS will track all such submissions and appointments at weekly staffing meetings to ensure compliance, and to identify barriers and seek resolution as needed.

2/3/11

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 356 Continued From page 4
months later. The QMRP stated that the client had a dental appointment scheduled for January 24, 2011, preauthorization pending. At the time of the survey, the facility failed to ensure Client #1 received timely dental services follow-up.

W 356

W 391 483.460(m)(2)(ii) DRUG LABELING
The facility must remove from use drug containers with worn, illegible, or missing labels.

W 391

This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to remove medications that had missing labels from it's use, for two of the four clients in the sample. (Clients #2 and #4)

The findings include:

1. On December 15, 2010, at approximately 8:02 a.m., the Licensed Practical Nurse (LPN) was observed to place a bottle of Oxcarbapazine Oral Suspension 300 mg/5ml with a torn/missing label on the kitchen counter. During a face to face interview with the LPN on December 15, 2010 at approximately 7:50 a.m. it was acknowledged that the bottle of Oxcarbapazine Oral Suspension 300 mg/5ml had a torn/missing label and belonged to Client #4. Further interview revealed the pharmacist would be notified and the bottle of Oxcarbapazine Oral Suspension 300 mg/5ml would be replaced.

There was no evidence that the facility removed all medications that had torn labels from use.

2. On December 15, 2010, at approximately 11:10 a.m., the LPN was observed to place a bottle of Nasoex Spray 100 meg. with a torn label

The DON will observe med pass at least weekly to ensure quality and accuracy. The DON will train all nursing staff to alert her when medicines have damaged or missing labels, and she will ensure they are replaced by the pharmacy. The Medical Director and DRS will spot check for three months to ensure compliance.

d. See #1 above.

Handwritten signature

Handwritten signature

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 391	Continued From page 5 on the kitchen counter. During a face to face interview with the LPN on December 15, 2010 at approximately 11:12 a.m. it was acknowledged that the bottle of Nasoex Spray 100 meg. had a torn label and belonged to Client #2. Further interview revealed the pharmacist would be notified and the bottle of Nasoex Spray 100 meg. would be replaced. There was no evidence that the facility removed all medications that had torn labels from use.	W 391		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to furnish and maintain in good condition wheelchairs, chest harnesses, a lap tray, and foot rests as prescribed, for four of the seven clients in the facility. (Clients #1, #2, #6, #7) The findings include: 1. The facility failed to furnish and maintain in condition Client #1's wheelchair, as evidenced below: On December 14, 2010, at 12:08 p.m., observations conducted at the day program revealed Client #1 sitting in a wheelchair with a	W 436	1. The QMRP will complete an adaptive equipment assessment for each individual weekly. The QMRP will submit the assessment to the DRS and the appropriate clinician (if required) and vendor immediately upon noting that repair is needed. Proactively, the QMRP will seek training and clarification on how to clean various adaptive equipment components such as the chest harness to ensure that they are not damaged and are in good working order as well as clean. The DRS will follow up weekly to ensure that the assessments are completed on time and that the vendor has all authorizations and clinical specifications required to complete repairs in the earliest possible timeframe.	2/3/11

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436 Continued From page 6

lap tray awaiting lunch. When asked if there were any issues/concerns regarding Client #2's wheelchair, the classroom coordinator (CC) indicated that the left strap for the chest harness would not snap into place, the lap tray was broken, and the wheelchair had a worn out cable which caused the wheelchair to tip backwards if you pressed down on firmly. This was verified through closer observations of the client's wheelchair at approximately 12:14 p.m. In addition, black duck tape was also observed on the wheelchair foot rest, arm rest, and on the side of the seating system.

Interview with the day program's case manager (CM) on the December 14, 2010, at approximately 12: 50 p.m., revealed that he communicated this concern with the facility through the day program's "Intra-Agency Communication" form on May 12, 2010. Further interview revealed that the day program's physical therapist (PT) had assessed Client #2's wheelchair on May 10, 2010, at the day program. According to the PT note, the "client requires multiple repairs to her wheelchair. Staff complain that the wheelchair tilts spontaneously. Staff reported this poses a safety risk as the wheelchair will tilt during transfers and pushing the wheelchair. Please repair the hydraulics."

Interview with the facility's qualified mental retardation professional (QMRP) on December 14, 2010, at approximately 5:15 p.m., revealed that she had not received any communication form from the day program regarding Client #2's recent wheelchair concerns. The QMRP indicated that she was not aware that the client's wheelchair would tilt backwards when heavy pressure was applied and that the left chest

W 436

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
W 436	Continued From page 7 harness strap would not snap into place. When asked to see a wheelchair evaluation form, the QMRP was not able to produce one. At approximately 5:20 p.m., the QMRP stated that she talked with the PT via telephone and he stated that he would evaluate Client #1's wheelchair at the day program on December 15, 2010. Interview with the residential director (RD) on December 14, 2010, at approximately 5:30 p.m., revealed that Client #1's has had numerous wheelchair repairs since May 2010. (This was verified through record verification of the facility's adaptive equipment log book on December 15, 2010, at approximately 9:30 a.m.). The RD indicated that the facility's PT assessment dated September 2010 recommended that Client #1 would benefit from a new wheelchair. However, the assessment did not state the condition of the wheelchair at that time. The RD stated that a 719a form was submitted for a new wheelchair for the client on October 6, 2010. This was also verified through record review and a telephone interview with the facility's office personnel on December 15, 2010 at approximately 10:00 a.m. On December 15, 2010, at approximately 12:20 p.m., the QMRP provided the surveyor with a copy of the physical therapist evaluation dated December 15, 2010 of Client #1's wheelchair which noted the following wheelchair conditions: a. Seating System - Molded system is worn. The back is superior and does not fit her deformity. b. Hydraulics - The seat will spontaneously tilt back. The hydraulics is damaged.	W 436	

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4964 ASTOR PLACE, SE WASHINGTON, DC 20019
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436	<p>Continued From page 8</p> <p>c. Arm Rest - The left arm rest does not remove because it is pressed against the seat. There is tape over left arm rest cushion.</p> <p>d. Wheels/Tires - All four tires are worn.</p> <p>e. Chest Harness - The left lower dip does not secure</p> <p>f. Headrest - Misaligned</p> <p>g. Lap tray - Left arm rest bracket is broken. Right bracket is misaligned.</p> <p>h. Other parts - no anti-tippers</p> <p>Recommendations: New wheelchair with custom molded seating system. Align her back cushion and headrest. Repair hydraulics. Align left arm rest. New left arm rest cushion. Replace with four new tires. The clients needs a new lower chest harness dip. New arm rest bracket on lap tray.</p> <p>A second interview with the QMRP on December 15, 2010, at approximately 1:00 p.m., revealed that the client would remain home effective December 16, 2010 until the old wheelchair was repaired or until a new wheelchair was purchased. The QMRP also stated that the old wheelchair would be repaired by an outside service technician. This was also verified through interview with the service technician on December 15, 2010, at approximately 1:30 p.m. The QMRP stated that she would forward the information to the department of health (DOH) once services are rendered.</p> <p>At the time of the survey, there was no evidence</p>	W 436		
-------	---	-------	--	--

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436 Continued From page 9
that Client #1's wheelchair was maintained in good repair.

2. The facility failed to ensure Client #7's wheelchair was maintained in good repair.

Observations of Client #7's wheelchair on December 16, 2010, at 1:55 p.m., revealed the left wheelchair tire was worn. In addition, the foot rest was ripped which was covered with black tape. This was acknowledged by the residential director (RD) who observed the client's wheelchair with the surveyor on the same day.

3. The facility failed to ensure Client #6's wheelchair was maintained in good repair.

Observations of Client #6's wheelchair on December 16, 2010, at 2:20 p.m., revealed the wheelchair needed covers for the hand breaks. This was acknowledged by the RD who observed the wheelchair with the surveyor on the same day.

4. The facility failed to ensure that Client #4 chest harness was maintained in good repair.

Observation on December 14, 2010, at 5:35 p.m. revealed Client #4's chest harness on her wheelchair was torn on the left side. Interview with the RD at the time of the observation, revealed that the client had recently received a new chest harness for her wheelchair.

Record review on December 15, 2010 at 10:47 a.m. revealed an adaptive equipment form dated October 28 2010 for Client #4 which stated "chest harness -replace chest harness straps, harness assembly." At approximately 11:50 a.m., the RD,

W 436

2. See response to #1.

3. See response to #1.

4. See response to #1.

2/13/11

2/13/11

2/13/11

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

PRINTED: 12/23/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 436	Continued From page 10 revealed that the new harness had been damaged during laundering and additional training to staff was provided to prevent further damage to the chest harness. At the time of the survey, however, there was no evidence the facility had implemented proactive strategies to maintain the client's chest harness in good repair.	W 436		
-------	---	-------	--	--

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1 000 INITIAL COMMENTS

A licensure survey was conducted on December 14, 2010, through December 16, 2010. Due to systemic deficient practices identified during the August 2010 investigation, the State Agency determined that the full survey process would be utilized. A random sample of four residents was selected from a residential population of seven females with various degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and one day program, interviews with staff in the home and one program, as well as a review of the clinical, administrative, and habilitative records; including a review of the unusual incident/investigation reports.

1 000

1 090 3504.1 HOUSEKEEPING

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by: Based on observation and interview, the group home for mentally retarded persons (GHMRP) failed to ensure that the environment was free from potential safety hazards.

The finding includes:

On December 16, 2010, beginning at 9:15 a.m., the surveyor was accompanied by the residential director (RD) to conduct observations of the interior and

1 090

Health Regulation Administration

Marsha H. Thompson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Chief Operating Officer

(X6) DATE

1/3/11

STATE FORM

8600

7N1Y11

If continuation sheet 1 of 7

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

I 090 Continued From page 1
exterior of the environment of the facility.

- The cable cord was noted to be hanging loosely from the roof and was looped outward, and approximately 3 feet from the ground, at the rear of the house.
- The cover was missing from the floor drain in the utility room. Closer observation of the drain reveal a small object inside. There was an accumulation of dirt on the floor of the utility room.
- Trash was observed behind the washer and dryer located in the laundry room.
- The coving was observed to be detached from the wall behind the head of the bed of Resident #6.
- The oven of the range in the kitchen was observed to be soiled on the interior.

These findings were acknowledged by the RD during the inspection of the environment on December 16, 2010.

I 090

- The Maintenance Department will remove, replace, or refasten the cord as needed. *2/3/11*
- The Maintenance Department will repair the drain if needed and replace the cover. The Home Manager will ensure the floor is cleaned. *2/3/11*
- The Home Manager will ensure that the trash is removed from behind the washer and dryer. *2/3/11*
- The Maintenance Department will make repairs to the wall. *2/3/11*
- The Home Manager will ensure the range and oven are cleaned, and assign specific staff to maintain its cleanliness. *2/3/11*

I 180 3508.1 ADMINISTRATIVE SUPPORT

Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for mentally retarded persons (GHMRP) failed to ensure that the qualified mental retardation professional (QMRP) integrated, coordinated and monitored the active

I 180

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 180	Continued From page 2 treatment program for five of seven residents residing in the facility. (Residents #1, #3, #4, #6, and #7) The finding includes: 1. Cross Refer to W436. The QMRP failed to ensure that residents' prescribed adaptive equipment (i.e. wheelchairs, chest harness, lap trays, etc. were maintained in good condition, for Residents #1, #4, #6, and #7. 2. Cross refer to W252. The QMRP failed to ensure that data was consistently and accurately maintained to monitor Resident #3's tolerance of her wrist splints.	I 180	1. See response to federal deficiency W436. 2. See response to federal deficiency W252.	12/16/10 12/16/10
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS 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 observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide professional services that included treatment services, and services designed to prevent deterioration or further loss of function by the resident, for one of four residents in the sample. (Resident #1) The finding includes: On December 14, 2010, at 12:05 p.m., observations conducted at the day program	I 401	See response to federal deficiency W356.	12/16/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

I 401 Continued From page 3

revealed Resident #1's was observed to have a heavy build up plaque and discoloration (yellowish) around her teeth. Review of Resident #1's medical record on December 15, 2010, at approximately 11:10 a.m., revealed a dental consultation dated March 2, 2010. The dentist noted "moderate calculus deposit. Patient needs scaling, will submit Pre-authorization for approval..." Please call if we have not contacted you in two months. Further record review revealed the resident went back to the dentist on July 19, 2010. The dental consultation noted "Patient has very poor oral hygiene. Large deposits of plaque and calculus present on all teeth surfaces. Diagnoses: Halitosis/Periodontitis. Full mouth scaling is indicated. Preauthorization request will be submitted..."

Interview with the qualified mental retardation professional (QMRP) on December 16, 2010, at approximately 1:20 p.m., revealed that the resident had not returned back to the dental office since July 19, 2010. Further interview with the QMRP revealed that Resident #1 had not received any dental treatment since May 11, 2009, over 19 months later. The QMRP stated that the resident had a dental appointment scheduled for January 24, 2011, preauthorization pending. At the time of the survey, the GHMRP failed to ensure Resident #1 received timely dental services follow-up.

I 401

I 420 3521.1 HABILITATION AND TRAINING

Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.

I 420

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

I 420 Continued From page 4

This Statute is not met as evidenced by:
Based on observation, interview, and record review, the group home for mentally retarded persons (GHMRP) failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective, for one of four residents in the sample. (Resident #3)

The finding includes:

The facility failed to ensure that data required to monitor Resident #3's tolerance of her wrist splints was consistently and accurately maintained.

Observation in Resident #3's bedroom on December 14, 2010, at 3:30 p.m. revealed bilateral wrist splints. Later that day, interview with staff at 4:57 p.m. revealed that the resident wore them at night while she was sleeping.

Interview with the Licensed Practical Nurse (LPN) on December 15, 2010, at 2:05 p.m. revealed the resident had a treatment order to "wear resting hand splints to both hands from 9:00 p.m. to 5:00 a.m." The nurse indicated that the resident was to gradually increase the amount of time she tolerated the splints up to 8 hours. Continued discussion with the LPN at approximately 2:50 p.m. indicated staff should monitor the resident's tolerance of the wrist splints and document it on the data collection form. During this discussion, the qualified mental retardation professional (QMRP) stated that staff reported that the resident hollered at times and did not want to wear the wrist splints.

Record review on December 15, 2010, at 2:05 p.m. revealed a physical therapy (PT) goal dated

I 420

See response to federal deficiency W391.

2/3/11

See response to federal deficiency W252.

2/3/11

PRINTED: 12/23/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

I 484 Continued From page 6

interview revealed the pharmacist would be notified and the bottle of Oxcarbapazine Oral Suspension 300 mg/5ml would be replaced.

There was no evidence that the facility removed all medications that had torn labels from use.

2. On December 15, 2010, at approximately 11:10 a.m., the LPN was observed to place a bottle of Nasoex Spray 100 meg. with a torn label on the kitchen counter. During a face to face interview with the LPN on December 15, 2010 at approximately 11:12 a.m. it was acknowledged that the bottle of Nasoex Spray 100 meg. had a torn label and belonged to Resident #2. Further interview revealed the pharmacist would be notified and the bottle of Nasoex Spray 100 meg. would be replaced.

There was no evidence that the facility removed all medications that had torn labels from use.

I 484

2. See response to federal deficiency W391: 2/13/11