

PRINTED: 06/06/2011  
FORM APPROVED  
OMB NO. 0938-0391

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G192 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/19/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>INDIVIDUAL DEVELOPMENT, INC. | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3312 4TH STREET, SE<br>WASHINGTON, DC 20032 |
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W 000 INITIAL COMMENTS

A recertification survey was conducted from May 17, 2011 through May 19, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of six males with various levels of intellectual disabilities.

W 000

*Received 6/17/11*

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

W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES

The facility must assure that outside services meet the needs of each client.

W 120

*6/30/11*

This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that outside services met the needs of each client, for one of the three sampled clients. (Client #2)

W120  
This Standard will be met as evidenced by:

The findings include:

1. The day program failed to ensure Client #2's communication program was implemented as recommended.

1. QDDP will conduct an in-service training at Client #2's Day Program on use of adaptive communication equipment. In addition, QDDP will conduct routine monitoring of client #2 program implementation to ensure compliance with the training as provided.

On May 17, 2011, at 11:19 a.m., Client #2 was observed at his day program. Upon entering his classroom, the day program staff asked the client to say "hi" to the surveyor. The client then made a noise and smiled. Continued observation revealed Client #2 was sitting in his wheelchair

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>[Signature]</i> Director of Residential Services | TITLE | (X6) DATE<br><i>6/16/11</i> |
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

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| W 120 | <p>Continued From page 1</p> <p>with his communication device attached to it. During this time, the day program staff was observed interacting and talking to Client #2. In response, the client uttered sounds, made gestures and smiled. At 11:36 a.m., a woman walked into the room and said "hi" to Client #2. The client then uttered a sound and smiled. Minutes later, the surveyor asked, does the client utilize his communication device? The day program staff said yes, then began to press the buttons, however, the communication device failed to operate. A few minutes later, the day program staff said the communication device was working then attached it back to the client's wheelchair. At 11:50 a.m., the day program staff asked the client if he was ready for lunch, however, the client was not prompted to use his communication device.</p> <p>Review of Client #2's individual program plan (IPP) dated July 2010, on the same day at approximately 11:52 a.m., revealed the following communication objective: "Given physical and model prompts [the client] will use a voice output communication device to express himself daily, 30% of the time, for three consecutive months". Continued review revealed the following strategies: "Staff will ensure the device is available to [the client] at all times. Staff will provide verbal encouragement, physical prompts, and model prompts as needed."</p> <p>Interview with the day program staff at 12:12 p.m., revealed Client #2 was required to use his communication device at all times, except lunch time. There was no evidence that the day program staff encouraged Client #2 to use his communication device.</p> | W 120 |  |  |
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W 120 Continued From page 2

2. The day program failed to ensure that Client #2 received a nutritionally balanced meal, in accordance with his prescribed diet.

On May 17, 2011, at 12:02 p.m., Client #2 was served mashed potatoes, pureed spinach and apple sauce. Ground ham was also observed on his plate; however he did not receive it.

Interview with the day program staff revealed, the texture of the ham was "grainy," instead of pureed, and therefore she did not give it to him. Further interview revealed no other pureed meat was available to offer to the client as a substitute for the ham, to ensure that he received a complete meal.

W 120

2. The QDDP will conduct an in-service training at Client #2's Day Program on his Mealtime Protocol, including mealtime menu and food consistency. In addition, the QDDP provided the day program with Client #2's Menu as written by the dietitian. The QDDP will conduct monthly day program visits to ensure compliance with the training as provided.

6/30/11

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 intellectual disabilities professional (QIDP) failed to ensure the active treatment program was integrated, coordinated, and monitored for five of six clients residing in the facility. (Clients #1, #2, #3, #4, and #5)

The findings include:

1. The QIDP failed to ensure Client #1 received training on personal skills essential for

W 159

W159  
This Standard will be met as evidenced by:

1. Reference W242
2. Reference W249
3. Reference W436

6/1/11  
6/16/11  
6/30/11

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| W 159              | Continued From page 3 independence. (See W242)<br><br>2. The QIDP failed to ensure continuous active treatment was provided for Client #2 using his recommended communication device. (See W249)<br><br>3. The QIDP failed to coordinate services to ensure that adaptive equipment/devices identified by the interdisciplinary team were maintained in good repair for Clients #2, #3, #4, and #5. (See W436)   | W 159         |   |                      |
| W 192              | 483.430(e)(2) STAFF TRAINING PROGRAM<br><br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to ensure staff demonstrated competency to address the needs of the clients, for one of three clients in the sample. (Client #1)<br><br>The finding includes:<br><br>On May 17, 2011, at 5:46 p.m., the direct care staff placed Client #1's dinner in front of him. The meal consisted of ground fish, rice, and tumip greens. The client then began to hit the table with his spoon and placed his mouth on the table. At 5:50 p.m., the direct support staff took the plate to the kitchen and stated, "He doesn't want it, I will try later." At 5:54 p.m., the direct support staff returned the food to the client, however, he did not eat it. At 6:12 p.m., the direct support staff | W 192         | W192<br>This Standard will be met as evidenced by:<br>Review of record noted that all staff received training on client #2's mealtime protocol on 4/10/11. The Dietitian also provided staff with a refresher training on 5/18/11 and 6/10/2011. In addition, a refresher training is provided to all staff on 6/10/11 The QDDP and RD will conduct routine monitoring of client #2 during mealtime to ensure staff follow protocol as outlined | 6/10/11              |

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| W 192 | <p>Continued From page 4</p> <p>pureed the client's foods individually and poured them into two-handle cups. The staff was observed to place each cup on the plate, one at a time, to allow him to drink the food.</p> <p>As the client rapidly drank his food from the cup, it spilled into the plate, on his shirt, and on the table. Continued observation revealed the staff poured the food from the plate back into the cup, then handed it to the client. Staff was observed to wipe the client's mouth during the meal. The staff was observed to offer the client his nutrition supplements at the end of the meal. During the meal, staff removed the spilled food from the client's eating area twice.</p> <p>On the same day at approximately 6:30 p.m., interview with the direct care staff who prepared the client's meal indicated that Client #1 was prescribed a ground diet; however, if he refused to eat, then staff should offer his meal in a pureed consistency inside a cup with a handle. Further interview with the licensed practical nurse at the same time revealed Client #1 had been refusing to eat a ground texture meal "for a while."</p> <p>On May 17, 2011, at approximately 6:45 p.m., review of the physician's order dated March 1, 2011, revealed Client #1 was prescribed a ground diet. At the same time, review of his mealtime protocol, dated April 2011, revealed the staff was required to implement the following recommendations:</p> <ul style="list-style-type: none"> <li>- Provide verbal prompts to swallow foods and liquids throughout the meal.</li> <li>- Verbally cue to maintain head in an upright position while swallowing.</li> </ul> | W 192 |  |  |
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W 192 Continued From page 5

- Encourage alternating of foods and liquids throughout the meal.
- Remove spilled foods from area to prevent eating.
- Assist in wiping spilled or expelled foods from mouth.

Review of the facility's in-service training records on May 18, 2011, at 3:30 p.m., revealed that staff had received training on Client #1's mealtime protocol on May 28, 2010, however, the mealtime protocol was updated in April 2011. On May 19, 2011, at approximately 1:00 p.m., the qualified intellectual disabilities professional (QIDP) provided documentation of staff training on May 18, 2011.

W 192

W 242 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN

The facility failed to ensure that the direct support staff were trained timely and effectively to implement the client's mealtime protocol.

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train each client in personal skills essential for independence, for one of the three clients in the sample. (Client 1)

W 242

W242  
This Standard will be met as evidenced by:  
QDDP has created ADL program to enhance client #1 independent through wiping his mouth.  
QDDP will follow up with IDT for further review and discussion at the coming ISP schedule for July 20, 2011.

6/1/11

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W 242 Continued From page 6

The finding includes:

On May 17, 2011, at 8:20 a.m., Client #1 was observed sitting in his wheelchair laughing and drooling heavily on his shirt. At 8:27 a.m., staff was observed to ask the client for permission to wipe his mouth and he allowed her to do so. Closer observation of the client revealed his right arm and hand were contracted; however, he was able to use his left arm and hand. On May 18, 2011, at 12:18 p.m., the client was observed using his left hand to hold cups of pureed food as he drank them from two handled cups, with minimal and occasional physical prompts.

Interview with the qualified intellectual disabilities professional (QIDP) on May 19, 2011, at 1:17 p.m., acknowledged that Client #1 was able to use his left hand and arm, and that his constant drooling was a concern. Further discussion with the QIDP, however, revealed the client had not been provided training to determine if he could benefit from learning to wipe his own mouth.

Review of the Speech Language Referral/Request for Swallow Study dated May 29, 2007, revealed Client #1 exhibited poor oral motor control of oral secretions both at rest and while eating, as evidenced by excessive drooling behavior. At the time of the survey, however, there was no evidence the client was provided training to increase his independence in personal hygiene (wiping mouth), to the extent of his capability.

W 242

W 249

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has

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| W 249 | <p>Continued From page 7</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:<br/>Based on observation, staff interview and record review, the facility's qualified intellectual professional person (QIPD) failed to ensure clients received continuous active treatment, for one of the three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Observation on May 17, 2011, at 8:20 a.m., revealed the direct care staff wheeled Client #2 from his bedroom. Client #2 then looked at the surveyor, uttered a sound and smiled. At 8:42 a.m., Client #2 uttered another sound then raised his hand. The Licensed Practical Nurse asked him, "Who are you trying to say hi to, is it her?" The client then looked at the surveyor and smiled.</p> <p>On May 17, 2011, at 4:10 p.m., review of the client's speech and language evaluation dated July 1, 2010, revealed the client will use a voice output device to communicate with persons in his environment. Further review revealed the consistent use of the device in the home and day program will significantly improve the client's quality of life as well as allow him to express himself in different situations in his environment.</p> | W 249 | <p>W249<br/>This Standard will be met as evidenced by:</p> <p>QDDP conducted staff training on client #2's speech communication program. QDDP will follow up with speech Pathologist for additional training. QDDP will routinely monitor client #2 program to ensure staff implement program as outlined.</p> | 6/16/11 |
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W 249 Continued From page 8  
Review of Client #1's individual program plan (IPP) dated July 20, 2010, on May 18, 2011, at 8:50 a.m., revealed an objective for Client #1 to use his low tech voice output communication device to communicate with persons in his environment on a daily basis.  
  
In an interview on May 19, 2011, at 4:00 p.m., the qualified intellectual disabilities professional (QIDP) acknowledged that the direct support staff did not implement Client #1's communication goal, which required the use of the client's "Smart /Scan 8 Pro" device.  
  
There was no evidence that the facility implemented Client #1's communication training program as recommended in the IPP.

W 249

W 331 483.460(c) NURSING SERVICES  
  
The facility must provide clients with nursing services in accordance with their needs.  
  
This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of one of three clients in the sample. (Client #3)  
  
The findings include:  
  
1. The facility's nursing services failed to ensure Client #3's neurology appointment was scheduled within the recommended timeframe, as evidenced below:  
  
Interview with the primary licensed practical nurse

W 331

W331  
This Standard will be met as evidenced by:  
  
Interview with the nurse indicated that client #3's Neurology follow up appointment was completed on quarterly basis (9/2/10, 10/12/10, 1/13/11 and 4/18/11) as outlined by the Neurologist. There is no evidence of any outstanding appointment for client #3.

5/19/11

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(PLPN) on May 17, 2011, at 3:15 p.m., revealed Client #3 had daily seizures, which were managed by anticonvulsant medications and the use of a vagus nerve stimulator (VNS). The PLPN also stated that the client went to the neurologist regularly to monitor the effectiveness of his VNS and anticonvulsant medications.

Record review on May 18, 2011, at 2:17 p.m., confirmed the PLPN's aforementioned statement concerning the management protocol for Client #3's seizures. Further record review, however, revealed on April 13, 2010, the neurologist recommended that the client return for follow-up in four to six weeks. Continued record review revealed the next neurology consultation report was dated September 2, 2010, five months later.

Further discussion with the PLPN on May 18, 2011, at 3:40 p.m., revealed there was no record of a neurology consultation for Client #3 between April 13, 2010, and September 2, 2010. There was no evidence that the nurse had coordinated services to ensure the client returned to the neurologist within the aforementioned recommended timeframe.

2. The facility's nursing services failed to document Client #1's partial refusal of his prescribed medication, as evidenced below:

On May 17, 2011, at 6:12 p.m., the LPN was observed preparing Client #1's medication. The nurse was observed to mix Docu Liquid 50 mg/5 ml, 10 ml and Enulose 10 mg/15 ml, 30 ml together. The nurse indicated that the client received both of the medications to prevent constipation. The nurse further revealed the

W 331

2: RN supervisor will provide additional training to LPN on medical administration protocols/policies and procedures. RN Supervisor and LPN will ensure ongoing compliance with this standard during the monthly Grand Round and on an ongoing basis

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G192 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/19/2011 |
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W 331 Continued From page 10  
client's medication was mixed because he sometimes would attempt to refuse it.

At 6:19 p.m., the nurse went to administer the medication to the client where he sat at the table eating, and mixed it with one of his cups of pureed food. The client refused approximately 50% of the portion of food, and therefore did not consumed all of the medication. Repeated attempts to get the client to take the medication revealed the food containing the medication drooled from his mouth onto the plate.

Review of the March 1, 2011 physician's orders on May 18, 2011, at 9:22 a.m., revealed Client #1 was prescribed the aforementioned medications to prevent constipation. Continued record review, however, revealed no evidence that the client's partial refusal of his stool softeners had been documented.

W 331

W 365 483.460(j)(4) DRUG REGIMEN REVIEW

An individual medication administration record must be maintained for each client.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure the medication administration record (MAR) documented all medication administered for one of three clients in the sample. (Client #1)

The finding includes:

Observation of the medication administration on May 17, 2011, at 7:54 p.m., revealed Client #1 received generic eardrops (Generic Debrox), 5

W 365

W365  
This Standard will be met as evidenced by:  
Interview with the nurse indicated that medication was administered to client #1 but nurse failed to sign the MAR. LPN Staff will receive in-service training on procedures regarding the administration /documentation of medication as ordered by physician  
RN Supervisor will review the record at least monthly on an ongoing basis.

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W 365 Continued From page 11  
drops in each ear. Observation of the medication container at that time verified the name, dosage, and the time the client was prescribed to receive the medication.

Interview with the the licensed practical nurse (LPN) on the same day at 7:53 p.m., revealed Client #1 received five drops of the medication in each ear for wax removal.

On the same day, at 7:55 p.m., the review of Client #1's medication administration record (MAR) dated May 1, 2011, revealed that the client was prescribed "Ear drops (Generic Debrox), 6.5% drops, 5 drops each ear daily for cerumen impaction till ENT appointment on May 20, 2011." Further review of the MAR, however, revealed the nurse failed to document the administration of the aforementioned ear drops on May 17, 2011.

Interview with the LPN on May 18, 2011, at approximately 5:15 p.m., acknowledged that he failed to document the administration of the ear drops administered to the client on the previous evening.

W 365

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 the record

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review, the facility failed to ensure adaptive equipment/devices identified by the interdisciplinary team as needed by the clients, was maintained in good repair for four of six clients residing in the facility. (Clients #2, #3, #4, and #5)

The findings include:

1. The facility failed to ensure the wheelchairs of Clients #2, #3, #4, and #5 were maintained in good repair, as evidenced below:

a. On May 17, 2011, at 4:50 p.m., Client #3's wheelchair anti-tippers were both observed turned upward, as he sat in his wheelchair. The qualified intellectual disabilities professional (QIDP) requested the client's 1:1 staff to pull the anti-tippers down, however, the staff stated that he had already tried, and was unable to reposition them. Further observation of the client's wheelchair revealed the vinyl covering on the armrests was taped and the left underarm pad on the wheelchair was also worn.

Interview with the QIDP on May 18, 2011, at 9:25 a.m., revealed the adaptive equipment specialist had attempted to adjust the client's anti-tippers during his visit earlier on the morning of May 18, 2011, however, was unsuccessful. On May 19, 2011, at 4:00 p.m., the QIDP indicated that the adaptive equipment specialist had agreed to return to the facility to provide maintenance on the immobile anti-tippers or to replace them, if needed.

b. On May 17, 2011, at 9:17 a.m., Client #5's wheelchair right anti-tipper was observed turned

W 436

W436  
This Standard will be met as evidenced by:  
Review of record indicated that QDDP/RD received training on adaptive equipment policies and procedures on 4/14/11. QDDP and Residential Director will receive additional training on Adaptive Equipment repairs and maintenance from the Director of Residential Services (DRS)

The QDDP and RD will follow and implement the established protocol system to ensure that adaptive equipment is maintained in good condition at all times.

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upward as staff rolled him to the van. Upon attempting to pull the anti-tipper to a down position, the staff stated that the anti-tipper was stuck in that position.

c. On May 17, 2011, at 4:55 p.m., Client # 4's right anti-tipper was observed to be broken off at the base. The back of the wheelchair seat (below the head rest) was observed to have worn foam padding. Additionally, the seat cover had a large hole in it, measuring approximately 4" by 9", causing the aforementioned worn area of foam padding to be exposed. The seat cover was also torn on the right side, exposing the foam padding.

Interview with the QIDP on May 18, 2011, at 8:47 a.m., revealed the adaptive equipment specialist replaced the broken right anti-tipper earlier on the morning of May 18, 2011. At the time of the survey, however, the cover and the padding on the seating system remained in poor repair. (Note: The surveyors review of the WAEC form used to monitor the condition of adaptive equipment on a weekly basis did not list anti-tippers.)

d. On May 18, 2011, at 9:13 a.m., Client #2's molded wheelchair was observed to have torn areas on both sides of the seat, which were partially covered with tape.

Interview with the QIDP on May 19, 2011, at 3:37 p.m., revealed that she reported the need for any adaptive equipment repairs to the administrative office on the Weekly Adaptive Equipment Checklist (WAEC). The QIDP indicated that upon receipt of the WAEC, the agency's designated adaptive equipment coordinator developed the agency-wide Adaptive Equipment Weekly Report

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| W 436  | <p>Continued From page 14</p> <p>(AEWR) summary. Continued discussion with the QIDP revealed that Clients #1, #2, and #3 were previously approved to receive new wheelchairs, however, the durable adaptive equipment provider went out of business, and the requests had to be resubmitted.</p> <p>On May 19, 2011, at 4:02 p.m., the most recent AEWR for the home provided for review was dated March 3, 2011, and revealed the following information:</p> <p>(1) Both cushions on Client #2's wheel chair were taped.</p> <p>(2) Clients #1, #2, and #3 need new custom molded wheelchairs.</p> <p>(3) Clients #2 and #3 needed seating evaluations for the recommended wheelchairs.</p> <p>(4) Client #1 needed a new 719A form for his wheelchair.</p> <p>At the time of the survey, however, the wheelchair delivery dates had not been determined. There was no evidence the facility had an effective system to ensure the residents' durable adaptive equipment was consistently maintained in good repair.</p> <p>2. The facility failed to ensure that Client #3's hospital bed was maintained in good repair, as evidenced below:</p> <p>On May 19, 2011, at approximately 1:30 p.m., observation of Client #3's hospital bed by the surveyor and residential manager revealed that the height could not be adjusted using the electrical control. The QIDP was informed of the problem with the bed and stated that she would ask the adaptive equipment specialist to check it.</p> <p>On May 19, 2011, at 2:50 p.m., interview with the adaptive equipment specialist revealed that he</p> | W 436  |   |
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**W 436** Continued From page 15  
checked the bed and noted that the motor required to adjust the height of the bed was not functioning. The QIDP revealed that the condition of adaptive equipment was monitored ongoing by staff, and that the condition of the equipment was documented on the "Weekly Adaptive Equipment Checklist (WAEC). The QIDP indicated that any adaptive equipment observed to be malfunctioning or in need of repairs should be reported immediately to the QIDP.

On May 19, 2011, at 3:40 p.m., review of the physician's orders dated March 1, 2011, revealed an ongoing physician's ancillary order dated May 14, 2009, for a "Hospital bed with bed rails and pads for support and safety." On May 19, 2011, at 3:29 p.m., review of the WAEC, however revealed it did not list hospital beds as equipment to be monitored. At the time of the survey, there was no evidence the facility ensured that Client #3's hospital bed was maintained in a fully operable condition.

W 436

**W 455** 483.470(l)(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, interview and record review, the facility failed to ensure proper infection control procedures, for two of the three clients in the sample. (Client #1 and #2)

The findings include:

1. On May 17, 2011, at 6:34 p.m., the direct

W 455

**W455**  
This Standard will be met as evidenced by:

1. DSP's have been retrained on Infection Control Procedures
2. Reference W192

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| W 455 | <p>Continued From page 18</p> <p>support staff was observed stirring a powdered thickener into Client #2's lemonade. The direct support staff then used the same spoon to scoop more thickener from the container. Interview with the direct support staff at the same time revealed that the same spoon was used to stir and scoop more thickener for the client's lemonade.</p> <p>Review of the training records on May 18, 2011, at 3:30 p.m., revealed that staff received infection control training on August 16, 2010. On May 19, 2011, at approximately 1:00 p.m., the qualified intellectual disabilities professional (QIDP) provided documentation of staff training on May 18, 2011.</p> <p>On May 19, 2011, at approximately 2:30 p.m., interview with the QIDP revealed that the Direct Support Staff should not use the same spoon to scoop the thickener and to stir the client's liquids.</p> <p>2. [Cross refer to W192]. On May 17, 2011, at 5:48 p.m., Client #1 began to hit the table with his spoon and placed his mouth on the table. At 6:12 p.m., the client was observed rapidly drinking pureed food from a two-handle cup. He spilled food into the plate, on his shirt and on the table. Continued observation revealed the staff poured the food from the plate back into the cup, then handed it to the client.</p> <p>Review of the training records on May 18, 2011, at 3:30 p.m., revealed that staff received infection control training on August 16, 2010. On May 19, 2011, at approximately 1:00 p.m., the qualified intellectual professional person (QIDP) provided documentation of staff training on May 18, 2011.</p> | W 455 |  |  |
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| W 455 | Continued From page 17<br>There was no evidence the staff used infection control measures while assisting the client in eating his meal. | W 455 |  |  |
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| 1 000 | <p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from May 17, 2011 through May 19, 2011. A random sampling of three residents was selected from a residential population of six males with various levels of intellectual and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports</p>  | 1 000 |  |  |
| 1 090 | <p><b>3504.1 HOUSEKEEPING</b></p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of six of six residents. (Residents #1, #2, #3, #4, #5, and #6)</p> <p>The findings include:</p> <p>On May 19, 2011, beginning at 1:12 p.m., the surveyor was accompanied through the facility by the residential manager to conduct observations of the environment. The following concerns were identified:</p> <p>1. The gutter on the rear of the facility was bent downward, on the side of the facility near the trash cans.</p> | 1 090 |  |  |

Health Regulation & Licensing Administration

*[Signature]* Director of Residential Services TITLE

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

6/16/11 (X5) DATE

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDIVIDUAL DEVELOPMENT, INC.</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3312 4TH STREET, SE<br/>WASHINGTON, DC 20032</b> |  |  |
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| I 090   | Continued From page 1<br><br>2. The towel rack located in the shower of bathroom #2 was not secured tightly to the wall. The towel rack in the shower of bathroom #1 was observed to pull completely out from the stabilizing ends, when pressure was applied. The bar was replaced during the survey, however continued to not be tightly secured to the wall.<br><br>3. Soil accumulation was observed on the floor of the utility room, near the hot water heater.<br><br>4. Water was observed leaking from the faucet of the kitchen sink when the the cold water control knob was turned to an off position.<br><br>5. A dark gray substance, approximately 3/4" wide and 12" long was observed applied to interior surface of the left kitchen sink. Further observation revealed the surface of the same sink had numerous small cracked areas. Interview with the qualified intellectual disabilities professional (QIDP) revealed that the gray substance had been applied to the sink to seal a surface crack approximately one year prior to the survey. [This is a repeat deficiency]<br><br>6. A large muddy area was observed in the yard between the facility and the driveway.<br><br>7. Multiple small dead limbs were observed hanging down from the tree on the right side of the house.<br><br>During the observations, the aforementioned concerns were acknowledged by the residential manager. | I 090  | 3504.1<br><br>This Stature will be met as evidenced by:<br>1. The facility maintenance crew has cleaned the gutter on the rear of the facility.<br><br>2. The facility maintenance crew has secured the lower rack in the shower of bathroom #1 and bathroom #2<br><br>3. The facility staff has cleaned out the soil on the floor of utility room<br><br>4. The facility maintenance crew has repaired the faucet on the kitchen sink<br><br>5. The facility maintenance crew has completed a repair of the surface of the kitchen sink.<br><br>6. The facility maintenance crew has cleaned up the muddy area in the yard between the facility and the driveway<br><br>7. The facility maintenance crew has trim and removed the dead limb on the tree on the right side of the house.<br><br>QDDP/RD manager will provide a periodic checklist of home environment/equipment and follow up with maintenance personnel for timely repair of facility equipment/environments. | 5/16/11<br><br>6/16/11<br><br>6/16/11<br><br>6/16/11<br><br>6/16/11<br><br>6/16/11 |
| I 180   | 3508.1 ADMINISTRATIVE SUPPORT<br><br>Each GHMRP shall provide adequate   | I 180  |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0050 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>05/19/2011 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>INDIVIDUAL DEVELOPMENT, INC. | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3312 4TH STREET, SE<br>WASHINGTON, DC 20032 |
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| I 180 | <p>Continued From page 2</p> <p>administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by:<br/>Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative support to meet the habilitation needs of five of six residents in the residing in the facility. (Residents # 1, #2, #3, #4, and #5).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The qualified intellectual disabilities professional (QIDP) failed to ensure Resident #1 received training on personal skills essential for independence. (See W242)</li> <li>2. The QIDP failed to ensure continuous active treatment using his communication device was provided for Resident #2. (See W249)</li> <li>3. The QIDP failed to ensure that adaptive equipment/devices identified by the interdisciplinary team were maintained in good repair for Residents #2, #3, #4, and #5. (See W436)</li> </ol> | I 180 | <p>3508.1<br/>This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Cross Reference W242</li> <li>2. Cross Reference W249</li> <li>3. Cross Reference W436</li> </ol> | 6/1/11<br>6/6/11<br>6/30/11 |
|-------|--|-------|---|-----------------------------|

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|-------|--|-------|--|--|
| I 222 | <p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by:<br/>Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure a continuous, ongoing in-service training program</p> | I 222 |  |  |
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| NAME OF PROVIDER OR SUPPLIER<br><br>INDIVIDUAL DEVELOPMENT, INC. |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>3312 4TH STREET, SE<br>WASHINGTON, DC 20032 |   |                    |
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| 1401   | Continued From page 4<br><br>2. The facility's nursing services failed to ensure that prescribed ear drops, which were administered to Resident #1, were documented on the medication administration record (MAR). [See Federal Deficiency Report - Citation W365]  | 1401   |   |                    |
| 1420   | 3521.1 HABILITATION AND TRAINING<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record review, the GHPID failed to ensure each resident was provided with habilitation and training to enable them to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning for one of three residents in the sample. (Resident #1)<br><br>The finding includes:<br><br>The GHPID failed to train Resident #1 on personal skills (wiping his mouth) essential for independence, for Resident #1. [See Federal Deficiency Report - Citation W242] | 1420   | 3521.1<br>This Statute will be met as evidenced by:<br><br>Cross Reference W242                                 | 6/1/11             |
| 1422   | 3521.3 HABILITATION AND TRAINING<br><br>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.<br><br>This Statute is not met as evidenced by:   | 1422   | 3521.3<br>This Statute will be met as evidenced by:<br>Cross Reference W249                                     | 6/16/11            |

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| 1422   | <p>Continued From page 5</p> <p>Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that one of three residents in the sample received continuous active treatment to support achievement of the individual program plan (IPP) objectives identified by the interdisciplinary team (IDT). (Resident #2)</p> <p>The finding includes:</p> <p>The GHPID failed to ensure Resident #2 received continuous active treatment using his communication device as recommended by his IPP. [See Federal Deficiency Report - Citation W249]</p> | 1422   |   |
| (X5) COMPLETE DATE   |   |  |   |