

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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2011
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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 000 INITIAL COMMENTS

A recertification survey was conducted from November 30, 2011 through December 1, 2011. A sample of three clients was selected from a population of six women with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations and interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.

W 000

Renewal 1/8/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by: Based on interview and review of the client's records, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator, for one of the three clients in the sample. (Client #1)

The findings includes:

On November 29, 2011, at approximately 5:30 p.m., a request of the facility's incidents and any corresponding investigative reports were made to the facility's qualified intellectual disabilities professional (QIDP). On November 30, 2011, at approximately 3:30 p.m., the facility's incident

W 153

W153
This Standard will be met as evidenced by:
The QDDP who was assigned to the home is no longer employed at IDL. The new QDDP has been trained on incident management policies and procedures. It is the expectation that all incidents are reported to the administrator in a timely fashion. The Home Management staff will be retrained on reporting incidents as it relates to injuries.

1/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> Director of Residential Services	TITLE 12/30/11	(X6) DATE
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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 153	<p>Continued From page 1</p> <p>management coordinator (IMC) delivered the incident reports and corresponding investigative reports to the facility;</p> <p>Review of the facility's incident reports on December 1, 2011 beginning at 9:00 a.m. revealed, the following:</p> <p>On September 16, 2011, staff discovered a small mark under Client #1's left eye. On December 1, 2011, at approximately 11:30 a.m., an interview was held with the house manager (HM) and the qualified intellectual disabilities professional (QIDP) to ascertain information related to the aforementioned injury. According the interview, the Incident Management Coordinator (IMC) completed an investigation but was not available for interview. Review of the corresponding investigation and Client #1's record failed to identify any information related to the size of the injury, measures used to treat the injury, or the status of the injury as it healed. Additionally, further review of the investigation revealed that the licensed practical nurse (LPN) categorized the injury as a "bruise." Further review of the incident report revealed that the administrator was notified of the injury on September 19, 2011, three days after it occurred. At the time of the survey, the facility failed to ensure the administrator was immediately notified of Client #1's injury.</p>	W 153		
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by:</p>	W 154		

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W 154: Continued From page 2
Based on interview and record review, the facility failed to ensure all injuries of unknown origin and medication errors were investigated, for one of the two clients in the sample. (Client #1)

The finding includes:

Review of the facility's incidents reports, including available corresponding investigative reports, on December 1, 2011, beginning at 9:00 a.m., revealed that on September 16, 2011, staff discovered a small mark under Client #1's left eye. Review of the investigation report dated October 7, 2011, on December 1, 2011, at approximately 11:00 a.m., the incident management coordinator (IMC) interviewed "only" the license practical nurse (LPN). The LPN stated that upon the client's return from day program the LPN observed a bruise on Client #2's left eye; the staff revealed that they did not observe anything from that morning; and the qualified intellectual disability professional (QIDP) stated that the client bumped her eye while in bed and didn't tell anyone initially.

The facility failed to ensure that this injury of unknown origin was thoroughly investigated for Client #1's bruise under her left eye.

W 154
W154
The Incident Management Coordinator will amend his investigation of the incident for Client #1 to include all pertinent interviews. The COO and DRS will continue to review the IMC's investigations for thoroughness and accuracy.

1/15/12

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

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W 159	<p>Continued From page 3</p> <p>review, the facility's qualified intellectual disability professional (QIDP) failed to ensure the coordination of services to promote the health and safety, for two of the three sampled clients. (Clients #1 and #3).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QIDP failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended by the interdisciplinary team. [See W227] 2. The facility's QIDP failed to ensure clients received continuous active treatment. [See W249] 3. The facility's QIDP failed to ensure the coordination of dental services. [See W356] 4. The facility's QIDP failed to ensure the maintenance and oversight of adaptive equipment. [W436] 	W 159	<p>W159</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. See W227 2. See W249 3. See W356 4. See W436 	11/5/12
W 227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended by the interdisciplinary team, for one of the three</p>	W 227	<p>W227</p> <p>This Standard will be met as evidenced by: The QDDP will coordinate with OT for clarity on the recommendation for "client participation on self-feeding skills" The OT will update the assessment to if necessary to include a training program if deemed necessary.</p>	12/30/11

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W 227	<p>Continued From page 4 clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>During meal observations on November 29, 2011, at 5:15 p.m., a direct support staff was observed feeding Client #2 using a high sided divided plate, and a built up handle spoon.</p> <p>Interview with the staff at 5:30 p.m., indicated that Client #2 was dependent on staff during meals. At 6:00 p.m., the client was observed turning pages of several magazines.</p> <p>Review of Client #2's occupational therapy assessment dated November 2, 2010, on November 30, 2011, at 3:52 p.m., revealed a recommendation for client participation with emphasis on increasing her self-feeding skills. Review of the client's IPP dated April 5, 2011, on November 30, 2011, at 4:15 p.m., revealed no evidence of a training program to address the aforementioned recommendation made by the occupational therapist.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on December 1, 2011, at 11:00 a.m., revealed that she had been newly assigned to Client #2. Therefore was not aware of the recommended training objective and no training program had been developed prior to her arrival.</p>	W 227			
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed</p>	W 249			

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W 249	<p>Continued From page 5</p> <p>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, staff interview and record review, the facility failed to ensure clients received continuous active treatment, for one of the three clients in the sample. (Client #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On November 29, 2011, at 5:15 p.m., Client #2 was observed receiving her dinner. At 5:43 p.m., staff assisted the client to the living room area and staff turned on the television. At 5:58 p.m., the staff was observed assisting the client with using a communication device. The device had pictures of the client, a drink of liquid, a plate of food and a boom box/television. Once a picture was pushed the word was said. Staff was observed pushing the pictures of a plate of food and the boom box/television, to which one could hear a recorded message, "I am hungry" and "I want to watch television." <p>On November 29, 2011, at 6:40 p.m., interview with the direct care staff revealed that Client #2 used the device to express her wants.</p> <p>On November 30, 2011, at 2:50 p.m., review of Client #2's Individual program plan (IPP) dated April 4, 2011, revealed a program objective which stated, "Given model demonstration, [the client] will activate a low tech communication device in</p>	W 249	<p>W249</p> <p>QIDP will train the staff on active treatment to include program documentation.</p> <p>QIDP will periodically complete in home observations of the implementations of the goals for all Individuals in the home.</p>	1/15/12	

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W 249	<p>Continued From page 6</p> <p>response to query related to four basic wants and needs with 80% mastery for 8 of 10 trials per session as measured by active treatment documentation."</p> <p>On November 30, 2011, at 3:30 p.m., review of Client #2's speech assessment, dated March 6, 2011, revealed that she had severe speech and language deficits. The assessment recommended that the client receive exposure to cause and effect activities to increase her overall responsiveness.</p> <p>Interview with the HM on November 30, 2011, at approximately 7:00 p.m., revealed that the client should use her communication device to express her wants, needs and/or desires prior to the selection presented to her. The staff, however, failed to implement Client #2's communication goal as written. They did not present the voice output/picture communication board to Client #2 prior to (or during) mealtimes or leisure activity.</p> <p>2. Client #2 did not participate in her standing program, as evidenced by the following:</p> <p>Observations were conducted on Client #2 on November 29, 2011, from 4:00 p.m., until 7:00 p.m. At 4:00 p.m., Client #2 arrived home from day program and staff was observed assisting the client into her bedroom. Upon return from Client #2's bedroom, the staff assisted the client to the living room, she watched television and participated in sensory activities involving smells and textures. At 5:15 p.m., Client #2 was observed receiving her dinner. After dinner at 5:43 p.m., staff assisted the client to the living room area and staff turned on the television. At</p>	W 249			

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W 249	<p>Continued From page 7</p> <p>5:58 p.m., the staff was observed assisting the client with using a communication device.</p> <p>Review of Client #2's Individual program plan (IPP) dated April 5, 2011, at 2:50 p.m., on November 30, 2011, revealed a program objective which stated, "[the client] will stand for at least 5 minutes every 30 minutes that she is awake at 100% accuracy for one month.</p> <p>On November 30, 2011, at 4:00 p.m., in an interview with the direct support staff who was assigned to Client #2 on the evening of November 29, 2011, revealed that the client did not participate in the standing program, as required.</p>	W 249		
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The staff failed to provide the client with the opportunity to participate in her standing program.</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's medical staff failed to ensure that each clients' medical appointments were scheduled as ordered, for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>During the medication administration observation, on November 29, 2011, at 7:11 p.m., the licensed practical nurse (LPN) was observed administering</p>	W 322	<p>W322</p> <p>RN will retrain the nurse on medical appointment management. The medical appointment was scheduled for 1/30/12. The QDDP will coordinate a monthly "ground round" with the nursing team to ensure appointments are being scheduled in accordance to recommendations. The RN will facilitate corrective action for the LPN(s) who failed to schedule the appointment as recommended.</p>	1/15/12

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W 322	Continued From page 8 Artificial Tears to Client #2. Review of Client #2's medical record on November 30, 2011, beginning at 10:02 a.m., revealed an ophthalmologist consult dated November 1, 2010. At that time, it was recommended that the client return in one year. Interview with the LPN and registered nurse (RN) on November 30, 2011, at approximately 12:30 p.m., confirmed that the client should have returned in one year. Further interview revealed that an appointment had not been scheduled but she would contact the ophthalmologist office and schedule an appointment for Client #2.	W 322			
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure routine laboratory testing as determined necessary by the physician, for one of the three clients in the sample. (Client #2) The finding includes: On November 29, 2011, beginning at 7:11 p.m., Client #2 was observed being administered Theophylline. During the medication administration, the licensed practical nurse (LPN) indicated that the medication was used to	W 325	W325 The Labs were completed on 12/8/11 RN will retrain the nurse on medical appointment management. The QDDP will coordinate a monthly "ground round" with the nursing team to ensure appointment are being scheduled in accordance to recommendations. The RN will facilitate corrective action for the LPN(s) who failed to schedule the appointment as recommended.	1/15/12	

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W 325	Continued From page 9 address the client's asthma. On November 30, 2011, beginning at 10:02 a.m., review of Client #3's physician's orders (POS) dated from November 2010 through November 2011, revealed a laboratory order for the client to receive a Theophylline laboratory study every three months. Subsequent review of her medical records revealed that her Theophylline levels were obtained on November 18, 2010 and February 21, 2011. Interview with the registered nurse (RN) on December 1, 2011, at approximately 1:30 p.m., confirmed that the studies were not completed every three months as ordered. The facility's nursing services failed to maintain an effective system to ensure that clients' laboratory studies were performed at the frequencies ordered by the primary care physician.	W 325		
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, staff interview and record review, the facility's nurse failed to ensure that each clients' medical appointments were scheduled as ordered, for two of the three clients in the sample. (Client #2 and #3) The findings include: 1. The facility's nursing staff failed to ensure	W 331	W331 1. See W325 2. See W356 3. See W368	1/15/12

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W 331	Continued From page 10 routine laboratory testing as determined necessary by the physician, for one of the three clients in the sample. [See W325] 2. The facility's nursing staff failed to ensure consistent oversight and monitoring of clients oral care and treatment. [See W356] 3. The facility's nursing staff failed to ensure that all prescribed medications were administered in accordance with clients' physician orders. [See W368]	W 331		
W 356	483.480(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 health. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure consistent oversight and monitoring of clients oral care and treatment for one of three sampled clients. (Client #3) The finding includes: Observation on November 29, 2011 at 5:55 p.m. revealed Client #3's speech was not clear and at times sounded slurred. Interview with Client #3's attending staff at the same time revealed Client #3 wore dentures and "they didn't always fit right." Because of this, the staff said, her speech can be a little difficult at times.	W 356	W356 Appointment has been scheduled for Client #3 has completed the dental appointment for her dentures. The QDDP will coordinate a monthly "ground round" with the nursing team to ensure appointment are being scheduled in accordance to recommendations. The RN will facilitate corrective action for the LPN(s) who failed to schedule the appointment as recommended.	12/31/11

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W 356 Continued From page 11

Record review on December 1, 2011 at 10:49 a.m. revealed Client #3 was seen by the dentist on July 19, 2011 and the findings detailed, "Adjusted upper denture ... Pt (patient) to wear upper only for 1 month and return for re-fitting of lower denture." Further record review revealed there was no evidence presented or on file that Client #3 returned to the dentist.

Interview with the Licensed Practical Nurse (LPN) on November 30, 2011 at 10:51 a.m. confirmed Client #3 had yet to return to the dentist to have her dentures refitted.

The facility failed to ensure that all clients received the proper and necessary dental services to ensure their health, well-being and safety.

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that all prescribed medications were administered in accordance with clients' physician orders, for one of the three clients in the sample. (Client #1)

The findings include:

On November 28, 2011, the State Agency (SA) received a phone call from the provider indicating that Client #1 received Augmentin 500mg beyond

W 356

W 368

W368
This Standard will be met as evidenced by:
The RN will facilitate corrective action for the LPN(s) who failed to document the medication according to physician's order. The LPN's will receive training on documentation and pharmacy coordination.

11/5/12

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

PRINTED: 12/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/01/2011
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) COMPLETION DATE
W 368	<p>Continued From page 12 the prescribed period of ten days.</p> <p>Review of Client #1's medication administration records (MAR) on December 1, 2011, at approximately 10:00 a.m., revealed the client received Augmentin 500 mg, twice a day for thirteen days, from September 25, 2011 until October 7, 2011. Review of the client's physician orders (POS) on December 1, 2011, at 10:15 a.m., revealed a STAT telephone order dated September 24, 2011, for the client to receive Augmentin 500 mg, twice a day, for ten days.</p> <p>Interview with the registered nurse on December 1, 2011, at approximately 10:30 a.m., revealed that Client #1 only received twenty pills from the pharmacist. She further indicated that the licensed practical nurse (LPN) continued to sign the MARs for three additional days.</p>	W 368		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received their adaptive equipment as prescribed for two of three sampled clients. (Clients #2 and #3)</p> <p>The findings include:</p>	W 436	<p>W436</p> <ol style="list-style-type: none"> Client #1 will receive training on the use of her back brace. If necessary the QDDP and PT will coordinate a scheduled for the Client #1 to wear her back brace. The new QDDP for the home has been trained on IDI's Adaptive Equipment Procedures. QDDP will continue to follow-up and documents on a weekly basis until Client #3's orthopedic shoes are secured See W356 	1/15/12

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W 436 Continued From page 13

W 436

1. On November 29, 2011, at 11:20 a.m., Client #2 was observed at her day program. Interview with the day program staff revealed the client did not have her back brace for the entire month of November 2011. Moments later, review of the day program's adaptive equipment tracking form confirmed the day program's statement.

On November 30, 2011, at approximately 4:00 p.m., interview with the nursing staff at Client #2's residential facility indicated the day program staff's statement was not true. She further indicated that she had worked on the day shift several times during the month of November 2011, and had personally put her back brace on prior to Client #2 leaving for her day program.

Observations on November 30, 2011, at 4:10 p.m., revealed Client #2 was wearing a back brace. Seconds later, in an interview with the house manager, she indicated that the client should wear her back brace at all times with the exception of sleeping and showering.

At the time of the observation on November 30, 2011, there was no evidence that the facility's staff were teaching Client #2's to use and make informed choices about the use of her back brace.

2. On November 29, 2011, at 5:11 p.m., Client #3 was observed wearing orthopedic shoes. Record review revealed she was seen by her Orthopedist on February 24, 2011. The findings were as follows, "unable to evaluate for heel wedge, lift do not have rail for pt (patient) to stand up. The recommendations were as follows, "need to

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W 436 Continued From page 14
re-evaluate w/therapist to determine definitive adjustment. If so, then need to know how high. Then would just need to drop off shoes w/719 form completely filled out. Do not need pt (patient) to come back."

Interview with the facility's Licensed Practical Nurse (LPN) and Registered Nurse (RN) on December 1, 2011, at 11:18 a.m., and review of the February 24, 2011, orthopaedic consult revealed Client #3's heel wedge was still pending further evaluation and repairs.

The facility failed to ensure the timely oversight and monitoring of client's adaptive equipment to ensure her health and safety.

3. The facility failed to ensure Client #3's dentures were refitted as recommended by the dentist to ensure a proper fit. [See W356]

W 436

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1090 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 persons with intellectual disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for four of the six residents of the facility. (Residents #1, #4, #5 and #6) The findings include: 1. On November 30, 2011, at 11:15 a.m., there were numerous, large scrapes observed on the paint in the bedroom shared by Residents #5 and #6. The most notable damage was observed on the closet doors and the wall between the closet doors. 2. On November 30, 2011, at 11:30 a.m., there were numerous, large scrapes observed on the paint in the bedroom shared by Residents #1 and #4. The most notable damage was observed on the closet doors and the wall between the closet doors.	1090	I090 This Statute will be met as evidenced by: 1. The large scrapes have been repaired. 2. The large scrapes have been repaired. In the future the RD for the home will thoroughly complete environmental walkthrough of the home and report any concerns to IDI's maintenance department.	12/11/11
1160 3507.1	POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member.	1160		

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Tiffany A. Samble - Director of Residential Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE 12/30/11

(X6) DATE

STATE FORM

6480

KJ3Q11

If continuation sheet 1 of 16

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I 160	<p>Continued From page 1</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 have a written policies and procedures manual on site and available for review by staff on the first day of the survey.</p> <p>The finding includes:</p> <p>On November 29, 2011, at 5:20 p.m., the house manager (HM), the qualified intellectual disabilities professional (QIDP) and the supervisory registered nurse (RN) stated they did not have an updated policies and procedures manual in the facility. The HM presented a manual that she had been given at orientation more than a year earlier and said it did not reflect the most recent policy changes. At 5:28 p.m., the QIDP stated that she would ask someone at their corporate office to bring a policies and procedures manual to the facility. On November 30, 2011, at 4:40 p.m., an agency employee brought a policies manual into the facility.</p>	I 160	<p>I160 This Statute will be met as evidenced by: All IDI homes were provided with new Standard Operating Procedures Manuals within the past 6 months. Director of Residential services will provide another copy of the manual to the home. The QDDP will be responsible for ensuring availability of the manual and that it reflects current policy changes. The DRS will request periodic reporting of the status of manuals in the home.</p>
I 183	<p>3509.4 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) qualified intellectual disability professional (QIDP) failed to ensure the coordination of services to promote the health and safety, for two of the three sampled clients. (Residents #1 and #3)</p>	I 183	<p>I183 This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. See W227 2. See W249 3. See W356 4. See W436

12/30/11

11/18/12

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I 183	Continued From page 2	I 183	
	<p>The findings include:</p> <ol style="list-style-type: none"> 1. The GHPID's QIDP failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended by the interdisciplinary team. [See W227] 2. The GHPID's QIDP failed to ensure clients received continuous active treatment. [See W249] 3. The GHPID's QIDP failed to ensure the coordination of dental services. [See W356] 4. The GHPID's QIDP failed to ensure the maintenance and oversight of adaptive equipment. [W436] 		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all health care professionals had current health certificates, for 5 of the 14 consultants. (C1, C2, C3, C4 and C5)</p> <p>The findings include:</p>	I 206	<p>I206</p> <p>Consultant #1, #2, #3, 4, #5 updated health certificates have been placed on file. IDI Office Management will ensure that documentation of all consultant's health status is maintained in accordance with policy and procedure/22 DCMR, Chapter 35. IDI Office management will keep a schedule when health certificates are expiring and follow-up with the consultants to secure a copy of the updated health certificate before the expiration date.</p>

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I 206. Continued From page 3 On November 30, 2011, beginning at 3:00 p.m., review of the personnel records failed to show evidence of a current physician's health inventory/certificate for the following: - psychologist 1 (C1); - psychologist 2 (C2) - nutritionist (C3) - psychiatrist (C4); and - pharmacist (C5). On November 30, 2011, at 3:35 p.m., the house manager acknowledged that there was no evidence of health inventories performed by a physician for the aforementioned personnel. She stated she would seek additional information from their corporate office. No additional information was presented before the survey ended the following day. This is a repeat deficiency. See Licensure Deficiency Report, dated November 12, 2010.	I 206		
I 261. 3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all the required administrative records were available for inspection, for two of the seven nurses providing services. (N1 and N2) The findings include:	I 261	I 261 This Statute will be met as evidenced by: Nurses N1 and N2 have current updated files. During the survey process QDDP and Human Resource Director will provide all files requested to the surveyors in a timely fashion.	12/30/11

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1261	Continued From page 4 On November 29, 2011, at 5:28 p.m., the qualified intellectual disabilities professional (QIDP) agreed to make available for review the personnel records of all employees, including nurses. On November 30, 2011, beginning at 1:15 p.m., review of the personnel records revealed no evidence of a current administrative record for two nurses (N1 and N2). At 2:30 p.m., the house manager said she would follow-up with the agency's main office. No additional information was presented before the survey ended the following day. With no record available for review, surveyors were unable to verify that the two nurses had current licenses to practice in the District of Columbia, maintained current CPR certifications and that they had current health certificates that were signed by a physician.	1261	
1271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure records were available for inspection by personnel of the Department of Health, Health Regulation and Licensing Administration. The findings include:	1271	

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1271	Continued From page 5 1. On November 30, 2011, beginning at 1:15 p.m., review of the personnel records failed to show evidence that S1 had received current Cardiopulmonary Resuscitation (CPR) certification. A signature sheet indicated that she had attended a training class on February 2, 2011; however, there was no evidence that she had completed all steps necessary for certification. On November 30, 2011, at 3:35 p.m., the house manager (HM) acknowledged that there was no evidence of current CPR certification for S1. At 3:45 p.m., the HM reported that their human resources officer had informed her by telephone that S1 had indeed passed the test. The HM further stated she would seek written documentation showing evidence that S1 had received an updated CPR certification; however, no additional information was presented before the survey ended the following day. 2. On November 29, 2011, at 5:28 p.m., the qualified intellectual disabilities professional (QIDP) agreed to make available for review the personnel records of all employees, including nurses. On November 30, 2011, beginning at 1:15 p.m., review of the personnel records revealed no evidence of a current administrative record for two nurses (N1 and N2). At 2:30 p.m., the house manager said she would follow-up with the agency's main office. No additional information was presented before the survey ended the following day.	1271	I271 This Statute will be met as evidenced by: <ol style="list-style-type: none">1. IDI's Human Resources Director and Training director will ensure that employees files are updated to reflect current certifications. The training director will coordinate with the CPR/First Aid instructor to ensure documentation of successful completion of the course is provided in a timely fashion.2. Nurses N1 and N2 have current updated files. During the survey process QDDP and Human Resource Director will provide all files requested to the surveyors in a timely fashion. Consultant #1 updated Health Certificate have been placed on file. IDI Office Management will ensure that documentation of all consultant health status is maintained in accordance with policy and procedure/22 DCMR, Chapter 35.	12/30/11
1379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of	1379		

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1379	<p>Continued From page 6</p> <p>Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and review of the resident's records, the group home for persons with intellectual disabilities (GHPID) failed to provide written notification the Department of Health (DOH) for one of the three residents in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>On November 29, 2011, at approximately 5:30 p.m., a request of the GHPID's incidents and any corresponding investigative reports were made to the GHPID's qualified intellectual disabilities professional (QIDP). On November 30, 2011, at approximately 3:30 p.m., the GHPID's incident management coordinator (IMC) delivered the incident reports and corresponding investigative reports to the GHPID.</p> <p>Review of the GHPID's incident reports on December 1, 2011, beginning at 9:00 a.m. revealed the following:</p> <p>On September 16, 2011, staff discovered a small mark under Resident #1's left eye. On December 1, 2011, at approximately 11:30 a.m., an interview was held with the house manager (HM) and the qualified intellectual disabilities professional</p>	1379	<p>1379 This Statute will be met as evidenced by: The Incident Management Coordinator will amend his investigation of the incident for Client #1 to include all pertinent interviews. The COO and DRS will continue to review the IMC's investigations for thoroughness and accuracy.</p>	11/15/12

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I 379	Continued From page 7 (QIDP) to ascertain information related to the aforementioned injury. According the interview, the Incident Management Coordinator (IMC) completed an investigation but was not available for interview. Review of the corresponding investigation and Resident #1's record failed to identify any information related to the size of the injury, measures used to treat the injury, or the status of the injury as it healed. Additionally, further review of the investigation revealed that the licensed practical nurse (LPN) categorized the injury as a "bruise." Further review of the incident report revealed that the administrator was notified of the injury on September 19, 2011, three days after it occurred. At the time of the survey, the GHPID failed to ensure the administrator was immediately notified of Resident #1's injury.	I 379		
I 399	3520.2(I) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (I) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that a copy of	I 399	I399 This Statute will be met as evidenced by: Consultant #1 current license and it has been placed on file. IDI Office Management will ensure that documentation of all consultants license's maintained in accordance with policy and procedure/22 DCMR, Chapter 35.	12/30/11

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1399	<p>Continued From page 8</p> <p>professional credentials was maintained for each individual providing professional services at the GHPID, for 1 of the 14 consultants (C6), as required by District of Columbia law, in the following discipline or area:</p> <p>(i) Speech and Language Therapy.</p> <p>The finding includes:</p> <p>On November 30, 2011, beginning at 3:00 p.m., review of the personnel records revealed the GHPID failed to have evidence that one of the two speech language pathologists under contract (C6) had a current license to practice in the District of Columbia. The record indicated that the speech language pathologist applied for a license on April 11, 2011.</p> <p>On November 30, 2011, at 3:35 p.m., the house manager acknowledged that there was no evidence of current a professional license for C6. She confirmed that the consultant had performed assessments for Resident #2 on March 6, 2011, respectively. She further confirmed that the consultant had provided in-service training for staff on February 15, 2011, after having revised the formal communication training programs for all six of the residents of the GHPID.</p>	1399	
1400	<p>3520.2(j) PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be</p>	1400	<p>1400</p> <p>This Stature will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. See W322 2. See W356 3. See W336 <p style="text-align: right;">M15/12</p>

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I 400	Continued From page 9 limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (j) Recreation This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) nurse failed to ensure that each clients' medical appointments were scheduled as ordered, for two of the three clients in the sample. (Resident #2 and #3) The findings include: 1. During the medication administration observation, on November 29, 2011, at 7:11 p.m., the licensed practical nurse (LPN) was observed administering Artificial Tears to Resident #2. Review of Resident #2's medical record on November 30, 2011, beginning at 10:02 a.m., revealed an ophthalmologist consult dated November 1, 2010. At that time it was recommended that the resident return in one year. Interview with the LPN and registered nurse (RN) on November 30, 2011, at approximately 12:30 p.m., confirmed that the resident should have returned in one year. Further interview revealed that an appointment had not been scheduled but she would contact the ophthalmologist office and schedule an appointment for Resident #2. 2. The facility's nursing staff failed to ensure the coordination of dental services to ensure all recommendations were met and address to	I 400		

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I 400	Continued From page 10 ensure the proper fitting of a client's dentures. [See W366] 3. The facility's nursing staff failed to ensure the timely coordination of orthopedic services to ensure the proper molding/refitting of a client's orthopedic shoes. [See W436]	I 400		
I 406	3520.8 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provided shall be documented in each resident's record. This Statute is not met as evidenced by: Based on record review and staff interview, the facility's nurse failed to ensure all treatment services were documented in accordance with the physician's orders for one of three sampled residents. (Resident #3) The finding includes: Interview with the case manager on November 30, 2011 at 12:41pm at Resident #3's day program revealed she received noon medications. The case manager presented a copy of the Medication Administration Record (MAR) and indicated Resident #3 received Cranberry Caplet (CC) 300mg x 2 Tabs and Pentoxifylline (PTX) 400mg tab at noon. Interview with the facility's Registered Nurse (RN) and a review of Resident #3's records on December 1, 2011, at 2:37 p.m. revealed several dosages of the CC and the PTX were not documented at the day program and were also not documented at the home. The facility's RN reviewed the MARs from the day program against the MARs at the home and confirmed the	I 406	I 406 The RN will facilitate corrective action for the LPN(s) who failed to document the medication according to physician's order. The LPN's will receive training on documentation. The RN will continue to monitor the MARS for accuracy. The RN will coordinate medication administration with the day program staff to ensure physician's orders are implemented as written.	1/15/12

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I 406	Continued From page 11 following documentation errors: 1. October 18, 2011 - CC and PTX not documented at day program and home. 2. September 19, 2011 - documentation for administering the medication was not clear on the MAR, the RN could not clarify the mark made on the MAR from the home. Unable to confirm if it was missed or administered; 3. August 12, 2011 - CC not documented at day program and home; 4. August 26, 2011 - CC and PTX missed at day program and home; 5. July 12, 2011 - CC not documented at home and day program; 6. July 19, 2011 - CC not documented at home and day program; 7. July 6, 2011 - PTX not documented at home and day program; 8. July 12, 2011 - PTX not documented at home and day program; 9. July 19, 2011 - PTX not documented at home and day program; 10. July 7, 2011 - CC not documented at home and day program; and 11. June 7, 2011 - PTX not documented at home and day program.	I 406		
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. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with	I 420	I420 This Statute will be met as evidenced by: The QDDP will coordinate with OT for clarity on the recommendation for "client participation on self-feeding skills" The OT will update the assessment to if necessary to include a training program if deemed necessary.	12/30/11

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I 420	<p>Continued From page 12</p> <p>Intellectual disabilities (GHP/D) failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended by the interdisciplinary team, for one of the three clients in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>During meal observations on November 29, 2011, at 5:15 p.m., a direct support staff was observed feeding Resident #2 using a high sided divided plate, and a built up handle spoon.</p> <p>Interview with the staff at 5:30 p.m., indicated that Resident #2 was dependent on staff during meals. At 6:00 p.m., the resident was observed turning pages of several magazines.</p> <p>Review of Resident #2's occupational therapy assessment dated November 2, 2010, on November 30, 2011, at 3:52 p.m., revealed a recommendation for the resident to participate with emphasis on increasing her self-feeding skills. Review of the resident's IPP dated April 5, 2011, on November 30, 2011, at 4:15 p.m., revealed no evidence of a training program to address the aforementioned recommendation made by the occupational therapist.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on December 1, 2011, at 11:00 a.m., revealed that she had been newly assigned to Resident #2. Therefore was not aware of the recommended training objective and no training program had been developed prior to her arrival.</p>	I 420	
I 422	3521.3 HABILITATION AND TRAINING	I 422	

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I 422	<p>Continued From page 13</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, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure residents received continuous active treatment for one of the three residents in the sample. (Resident #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On November 29, 2011, at 5:15 p.m., Resident #2 was observed receiving her dinner. At 5:43 p.m., staff assisted the resident to the living room area and staff turned on the television. At 5:58 p.m., the staff was observed assisting the resident with using a communication device. The device had pictures of the resident, a drink of liquid, a plate of food and a boom box/television. Once a picture was pushed the word was said. Staff was observed pushing the pictures of a plate of food and the boom box/television, to which one could hear a recorded message, "I am hungry" and "I want to watch television." On November 29, 2011, at 6:40 p.m., interview with the direct care staff revealed that Resident #2 used the device to express her wants. On November 30, 2011, at 2:50 p.m., review of Resident #2's individual program plan (IPP) dated April 4, 2011, revealed a program objective which stated, "Given model demonstration, [the resident] will activate a low tech communication device in response to query related to four basic wants and needs with 80% mastery for 8 of 10 trials per session as measured by active 	I 422	<p>I422 This Statute will be met as evidenced by: QIDP will train the staff on active treatment to include program documentation and implementation. QIDP will periodically complete in home observations of the implementations of the goals for all individuals in the home</p> <p>11/5/12</p>

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1422	<p>Continued From page 14</p> <p>treatment documentation."</p> <p>On November 30, 2011, at 3:30 p.m., review of Resident #2's speech assessment, dated March 6, 2011, revealed that she had severe speech and language deficits. The assessment recommended that the resident receive exposure to cause and effect activities to increase her overall responsiveness.</p> <p>Interview with the HM on November 30, 2011, at approximately 7:00 p.m., revealed that the resident should use her communication device to express her wants, needs and/or desires prior to the selection presented to her. The staff, however, failed to implement Resident #2's communication goal as written. They did not present the voice output/picture communication board to Resident #2 prior to (or during) mealtime or leisure activity.</p> <p>2. Resident #2 did not participate in her standing program, as evidenced by the following:</p> <p>Observations were conducted on Resident #2 on November 29, 2011, from 4:00 p.m., until 7:00 p.m. At 4:00 p.m., Resident #2 arrived home from day program and staff was observed assisting the resident into her bedroom. Upon return from Resident #2's bedroom, the staff assisted the resident to the living room, she watched television and participated in sensory activities involving smells and textures. At 5:15 p.m., Resident #2 was observed receiving her dinner. After dinner at 5:43 p.m., staff assisted the resident to the living room area and staff turned on the television. At 5:58 p.m., the staff was observed assisting the resident with using a communication device.</p>	1422		
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1422	<p>Continued From page 15</p> <p>Review of Resident #2's Individual program plan (IPP) dated April 5, 2011, at 2:50 p.m., on November 30, 2011, revealed a program objective which stated, "[the resident] will stand for at least 5 minutes every 30 minutes that she is awake at 100% accuracy for one month.</p> <p>On November 30, 2011, at 4:00 p.m., in an interview with the direct support staff who was assigned to Resident #2 on the evening of November 29, 2011, revealed that the resident did not participate in the standing program, as required.</p> <p>The staff failed to provide the resident with the opportunity to participate in her standing program.</p>	1422	