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

PRINTED: 09/29/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G121	A. BUILDING _____ B. WING _____	C 08/26/2009

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

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W 000	INITIAL COMMENTS The Health Regulation Licensing Administration (HRLA) received a report via e-mail on August 24, 2009, from University Legal Services (ULS) monitoring team. Attached to the e-mail was a report dated August 20, 2009 of an onsite visit completed by their nurse consultant who alleged that three class members were noted with significant deficiencies, as described below: (1) Three Class members experienced significant weight fluctuations in 2009. Due to the nature of this complaint, on August 26, 2009 two HRLA surveyors initiated an onsite investigation. The findings of the investigation were based on observations in the group home, interviews with direct care and administrative staff, and the review of the investigative and administrative records. As a result of the investigative findings, the state agency determined that the facility was not in compliance with standard level requirements, as evidenced by deficiencies cited throughout this report. The allegation involving the three class members experiencing significant weight fluctuations in 2009 was substantiated.	W 000	Received 11/4/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W156 W 156	This Standard will be met as Evidenced by: The QMRP will ensure that all investigations of injuries of unknown origin are reported to the administrator.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DCS (X6) DATE: 10/29/09

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

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W 156	Continued From page 1 failed to report the results of all investigations of injuries of unknown origin to the administrator within five working days of the incident, for two of the three clients involved in such incidents. (Clients #3 and #7) The findings include: On August 26, 2009 beginning at approximately 5:15 p.m., review of incident reports in the facility revealed that there had been three injuries of unknown origin reported since the last HRLA survey. Of those three incidents, only one had been investigated within five working days. The timeliness of two investigations could not be verified, as evidenced by the following: 1. According to an incident report dated January 16, 2009, a direct support staff observed "discoloration" on both of Client #7's hands. The corresponding investigation report was not dated. The Qualified Mental Retardation Professional (QMRP) was unavailable for interview and no available staff knew how soon after the incident the results of the investigation were forwarded to the Director of Residential Services. 2. Another incident report, dated April 29, 2009, documented that on that date, staff discovered "an open area on the left side of" Client #3's buttocks. A nurse on duty assessed the client and applied basic first aid. The investigation report indicated that the client had a history of recurrent decubitus ulcers. The report, however, was not dated. The QMRP was unavailable for interview and no available staff knew how soon after the incident the results of the investigation were forwarded to the Director of Residential	W 156	—W156 Continued... a. QMRP will receive additional training on incident reporting procedures, conducting timely investigations (within five day timeframe)signing and dating the document to reflect date completed, documenting and verifying that all results are forwarded for review by the administrator, and other agencies as required. b. Check list will be developed to further assist QMRP in ensuring that all aspects of the incident procedures are implemented. c. Incident reports/Investigations will be reviewed and signed by the designated administrator. d. Investigations will be filed into the incident report book for review. 1 and 2. QMRP has signed documents.	9 17 09 ongoing

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W 156	Continued From page 2 Services. The facility failed to document when the administrator was notified of the results of all investigations.	W 156		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee was provided with effective training required for accurate assessment of the clients' weights, for four of the seven clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: Cross-refer to W331.1. On August 26, 2009 beginning at 8:45 a.m., interviews with an LPN and the house manager revealed that weight variations had been documented for four of the seven clients, starting in May 2009. They indicated that the agency had suspected that weights recorded by a weekend nurse in early 2009 had not been measured accurately. Further interview revealed that the supervisory nursing staff had provided training to the nursing staff on the correct procedures for measuring clients' body weights. The date/time of the training, however, was unclear from the interviews. Subsequent review of the in-service training records failed to show evidence of said training on weighing techniques. The supervisory RN was unavailable at the time for interview. No	W 192	**W192** **This Standard will be met as Evidenced by:** Cross reference response to W331.1 All LPN staff will receive further training on the weighing process.	8.27.09 ongoing

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W 192	Continued From page 3 additional information was provided; therefore, a chronological history of nurse training on the facility's weighing protocol and procedures could not be verified.	W 192		
W 217	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nutritional assessments identified the current caloric needs for three of the four clients in the sample. (Client #2, #3 and #4). The findings include: 1. On August 26, 2009 at 8:45 a.m., interview with direct support staff revealed that Client #3 was totally dependent on staff for feeding and received a pureed diet. Interview the interim LPN at 9:17 a.m. revealed Client #3 was prescribed a pureed, low fat, low cholesterol, added fiber, nectar thick liquids diet. The nurse indicated that with the addition of a high calorie nutritional supplement twice daily to her diet, the client's weight was essentially stable. On August 26, 2009 at 9:20 a.m., review of the facility's monthly weight record documented that Client #3 experienced an 11-pound weight loss from April 2009 (114 pounds) to May 2009 (103 pounds). The nurse indicated that the client's weight loss/discrepancy was thought to have been due to an error in the weighing technique used by the assigned nurse. The interim nurse also indicated that although specific nursing staff had been assigned to weigh the clients, it was the	W 217	see page 10.	

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W 217	Continued From page 4 responsibility of the facility's primary nurse to monitor the clients' health status, including changes in body weights. Further interview with the interim LPN, however, failed to determine when the nutritionist was informed of Client #3's weight loss. Record review on August 26, 2009 at 9:37 a.m. did reveal a Nutritional Weight Evaluation dated July 3, 2009 for Client #3. Although this evaluation documented the client's weights of 114 pounds in April, 103.4 pounds in May, 102 pounds in June and 101.2 pounds in July, there was no evidence these weights were reviewed by the nutritionist until July 3, 2009. The facility's monthly Weight Chart showed a continued decline in weight to 100.8 pounds in August 2009. The July 3, 2009 Nutritional Weight Evaluation revealed the following statement: Client #3's "May weight reflects a significant loss of 11.6 pounds/10% in 30 days. Her weight since then exhibits a downward trend. Her weight remains at the lower half of her Healthy Weight Range. She is prescribed a regular portion diet to maintain her weight. Her appetite is good and no known changes in her care that can be attributed to her weight loss ....Since her weight is at the lower half of her body weight a nutritional supplement is recommended to prevent further weight loss." Review of Client #3's record on August 26 at 9:45 a.m., revealed a telephone physician's orders dated July 3, 2009, to "Provide eight oz Resource 2.0 (480 calories) once a day with Medication Pass for nutritional supplement." Review of Client #3's Third Quarterly Nutritional Review dated August 11, 2009 (for May, June, and July 2009) on August 26, 2009 at 10:09 a.m.	W 217		

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W 217	Continued From page 5 revealed that her weight continued to trend downward. In the August 11, 2009 review, the nutritionist recommended to "Increase Resource 2.0, eight ounces to 2 x day with medication pass, due to continued weight loss." Documentation on Client #3's August 2009 MAR revealed that she began receiving two 8 ounces of Resource 2.0 daily on August 11, 2009. Although high calorie nutritional supplements had been recommended for the client to prevent weight loss, the client continued to experience a gradual decrease in weight. Additionally, there was no evidence that Client #3's specific caloric needs had been reassessed after her weight loss began in May 2009. 2. On August 26, 2009 at 8:50 a.m., interview with direct support staff revealed that Client #2 was totally dependent on staff for feeding and received a pureed diet with supplemental feeding to prevent her from losing weight. Interview the interim LPN at 11:02 a.m. revealed Client #3 was prescribed a pureed diet and a high calorie nutritional supplement once a day to prevent weight loss. She further indicated that although the client had lost some weight, her weight had essentially stabilized. Record review on August 26, 2009 at 9:40 a.m. revealed a chart on which Client #2's 2009 weights were recorded. The chart documented the client's weight loss of 11 pounds from 103 pounds (May 2009) to 92 pounds (June 2009). Their monthly weight chart documented a weight of 93.8 pounds in July 2009. The July 2009 medication administration record (MAR) revealed a reweigh of 91.4 pounds on July 27, 2009. A monthly weight of 91.6 pounds was recorded on the weight chart for August 2009.	W 217		

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W 217	Continued From page 6 On August 26, 2009 at 10:20 a.m., review of the July 3, 2009 nutritional evaluation revealed the following statement: Client #2's "June weight reflects a 10.2 pound/10% significant weight loss in thirty days. Her weight has stabilized since then and is at the lower half of her Healthy Weight Range. She is prescribed a regular portion diet to maintain her weight. There are no other changes in her care that can be attributed to her weight loss. Her appetite is good.....Since her weight is at the lower half of her Healthy Weight Range, a nutritional supplement is recommended." Review of the client's physician's orders on August 26, 2009 at 10:40 a.m. showed that Resource 2.0 (480 calories) 8 oz daily was prescribed on July 3, 2009 in accordance with the nutritionist's recommendation on that date. On July 7, 2009, the PCP further ordered "Monitor weights weekly and record." However, review of the facility's aforementioned Monthly Weight Chart and the client's Weight/Blood Pressure Record showed that her weight continued to gradually decrease. Subsequent review of the June 2009 QMRP Monthly Progress Notes dated July 13, 2009 revealed Client #2's "weight shows a big discrepancy this month. Her current weight is 92 pounds which shows a weight loss of almost 12 pounds However, she continued to be within her healthy weight range (85 to 111 pounds) Consult with the PCP, Nurse and nutritionist to re-evaluate Client #2..... Day nurse to assess scale to ensure accuracy, and redo her weight. Meal time protocol is in place..monitor closely and report any significant change to the nutritionist immediately.	W 217		

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W 217	Continued From page 7	W 217		

Although the high calorie nutritional supplement had been provided as recommended by the nutritionist and prescribed by the PCP, there was no evidence that Client #2's caloric requirement had been reassessed after her June weight loss/discrepancy was identified.

3. On August 26, 2009 at 9:55 a.m., interview with direct support staff revealed Client #4 was prescribed a pureed diet and a nutritional supplement to help her gain weight. At 10:39 a.m., interview with the interim LPN indicated that the client had lost some weight, however her weight had stabilized since she started receiving more calories. Further interview with the interim LPN, however failed to verify when the nutritionist was informed of Client #4's weight loss.

On August 26, 2009 at 10:20 a.m., review of the facility's monthly weight record revealed that Client #4 weighed 76.2 pounds in April 2009. The same weight chart showed that Client #4 weighed 83 pounds at sometime in May 2009. A reweight later in May showed another weight (71.8 pounds) was documented. The client's Weight/Blood Pressure Record revealed weights of 76.2 pounds in April 2009, 72 pounds in May, and 68.2 pounds in June 2009. The nurse indicated that the client's initial weight change was thought to have been due to an error in the weighing technique used by the assigned nurse. Further interview with the nurse indicated that although specific nursing staff had been assigned to weigh the clients, it was the responsibility of the facility's primary nurse to monitor the clients' health status, including changes in body weights.

On August 26, 2009 at 3:00 p.m., Client #4's

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W 217	Continued From page 8 Third Quarterly Nutritional Review (for March, April, May 2009) dated June 25, 2009, documented the client's March 2009 (75.4 pounds) to May 2009 (71.8 pounds) weights, reflecting a 3.6 pound loss during this period. The nutritionist recommended that the client continue to be provided a low fat/cholesterol, added fiber, pureed tied with 8 ounces Boost Plus after dinner as prescribed. The review of the monthly Qualified Mental Retardation Professional summary revealed "Consult with nutritionist if weight loss/gain of 5 pounds is indicated within one month or if weight loss trend is indicated over 2-3 months." The record review, however, failed to verify that the nutritionist was aware of the weight changes/discrepancies or had assessed them until July 3, 2009. Review of the Nutritional Weight Evaluation dated July 3, 2009 on August 26, 2009 at 3:17 p.m. revealed the client's weight loss from 76.2 pounds in April 2009 to 68 pounds in June 2009. The July 3, 2009 nutritional evaluation revealed the following statement: Client #4's June 2009 weight reflected "a downward trend since the beginning of the year...She is prescribed a regular portion diet and a nutritional supplement once a day to maintain her weight that is at the lower half of her Healthy Weight Range (62 to 82 pounds). Her appetite is good ....there are no known changes in her care that can be attributed to her weight change. Since her weight is at the lower half of her healthy Weight Range, an increase in her nutritional supplement is recommended." The nutritional evaluation recommended to continue the supplement (Boost Plus, 8 ounces after dinner) and to "Provide 8 ounces of Resource 2.0, once a day with medication pass." Record review on August 26, 2009 at 3:57 p.m. revealed	W 217		

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W 217	Continued From page 9 a physician's order dated dated July 3, 2009 for Resource 2.0 (480 calories) 8 oz daily. Review of Client #4's Weight/Blood Pressure Record, showed a one pound increase to 69.8 pounds in July 2009 and then a decrease to 67.2 pounds in early August 2009. At the time of the investigation, there was no evidence that the client's specific caloric needs had been determined after the her weight loss/discrepancy was identified, beginning in May 2009.	W 217	W217 **This Standard will be met as evidenced by:** The LPN in coordination with the QMRP will review weight records closely, examine the appropriateness of the diet, adequacy of food intake, feeding practices, and conduct observations and monitoring to obtain greater insight. The Nutritionist will be requested to increase monitoring of individuals weight status as directed by the RN and/or interdisciplinary team. RN/LPN/ QMRP will document actions taken to address weight loss/gain of 5lbs. The Director of Nursing will update weight management protocols as needed. The RN will review weight records and verify documented weights as warranted.	9.11.09 ongoing
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 verification, the facility's nursing services failed to establish systems to provide accurate weight monitoring and identify services in accordance with clients' needs, for four of the four clients in the sample. (Clients #1, #2, #3 and #4) The findings include: On August 26, 2009 at 8:45 a.m., interview with the day nurse (an interim LPN) confirmed that weight variations had been an agency concern. The supervisory RN was unavailable for interview at the time; however, interview with an interim LPN (who normally worked in another of the agency's facility's) confirmed that only nurses weighed the clients. She indicated that systems had been implemented to address the weight concerns.	W 331		

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W 331	Continued From page 10 1. On August 26, 2009 at 8:45 a.m, review of a Monthly Weight Chart revealed the nurses documented the weights of all eight clients on the same form. Further review of the chart revealed that four of the clients had experienced a change of 5 pounds or greater within a one-month period. Additional review revealed that the facility's nursing staff failed to implement instructions that were included on the chart, as follows: "reweigh within 24 hours if weight change is 5 pounds or greater (loss or gain)." The chart showed that nurses had re-weighed a client within 24 hours in only one of the six instances, when they documented weight changes of 5 pounds or greater. Continued review of the chart, however, revealed the following: a. Client #1's weight dropped from 176.6 pounds in May to 171.4 pounds in June (5.2 pounds); b. Client #1's weight dropped again from 171.4 pounds to 166.4 pounds in July (5 pounds); c. Client #1's weight then increased 5.2 pounds to 171.6 pounds in August. d. Client #2's weight dropped 10.2 pounds from 103 pounds in May to 92.8 pounds in June 2009; and, e. Client #3's weight dropped 10.6 pounds between April (114 pounds) and May 2009 (103.4 pounds). Review of the clients' records revealed no evidence that the women were re-weighed on any of those 5 occasions. 2. The Monthly Weight Chart in the nursing office	W 331		

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W 331	Continued From page 11 showed that Client #4 was weighed 83 pounds at some time in May 2009. The chart then showed that she was re-weighed that month and another weight (71.8 pounds) was also documented. There were no dates provided for either weighing; therefore, it could not be verified whether she had been re-weighed after 24 hours, in accordance with the instructions. 3. According to various staff, the agency's weighing policies and procedures had been updated in recent months; however, this assertion could not be verified, as follows: a. On August 26, 2009 at approximately 9:20 a.m., interview with the House Manager indicated that until approximately 2 or 3 months earlier, the clients had been weighed on the first Saturday of every month. This reportedly had changed whereby nurses now rotated the duty. At approximately 10:06 a.m., the interim LPN said the practice of weighing the clients on the first Saturday of the month was being implemented in the agency's facilities. The nurse indicated, however, that she was providing temporary coverage at the group home and was unable to verify the days the client's were weighed. She agreed to seek the agency's current weighing policies. She was unable to locate said policies before the investigators left the facility that evening. On August 26, 2009 at 2:43 p.m., review of a document titled "Weekend Day Nurse Duties and Responsibilities" (not dated) revealed the following: "Weigh consumers on the third Saturday of each month. Document weight in the consumer's records. Notify physician of any abnormal weight gain or loss." There was no	W 331	W331 This Standard will be met as evidenced by: 1. The Director of Nursing completed additional training for LPN staff on weighing procedures and documentation. The Director of Nursing and RN assigned to the home will continue to monitor weight documentation procedures and re-weigh as outlined in policies and procedures. Other appropriate actions will be taken as needed to address weight loss/ gain.	9.11.09 ongoing

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

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	09G121	A. BUILDING _____ B. WING _____	C 08/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 331	Continued From page 12	W 331	W331. Continued...	

evidence that this document had been implemented or reviewed.

On August 26, 2009, 2:50 p.m., a Monthly Weight Chart was reviewed, which included the clients' weights for 2009. A typed entry at the top of the form documented "Reweight within 24 hours if weight change is 5 pounds or greater (loss or gain)." There was no evidence, however, that the clients were reweighed within 24 hours if the weight change was 5 pounds or greater (loss or gain), as previously mentioned

b. When interviewed by telephone on August 26, 2009, beginning at 4:06 p.m., the supervisory RN confirmed that agency nurses were to reweigh clients if/when there was a 5 pound or more change in weight She referred investigators to the Director of Nursing for the actual policy. This policy however was not presented for review when requested during the investigation.

The existence of these policies was discussed during the exit teleconference held on August 27, 2009; however, no additional information was shared with HRLA.

4. There was no evidence that facility's nursing services sought clarification and/or guidance from the primary care physician (PCP) after Client #1's team disagreed with a nutritionist's recommendation, as follows:

Client #1 had been receiving 4 cans of Jevity 1.5 bolus feeding via g-tube since July 9, 2009. Record review on August 25, 2009 at 12:45 p.m. revealed a July 8, 2009 Nutritional Weight Evaluation and corresponding Mealtime/Tube Feeding Guidelines, initialed by the primary care

2. The Director of Nursing will modify the Weight documentation form to include a mandated requirement for date. Training will be provided. 9.24.09
3. Director of Nursing will familiarize all staff with policies and procedures. Both Managers and LPN staff are expected to identify and provide documents upon request. Weight documentation and implementation is prescribed by the primary care physician and carried out monthly or as recommended. Documentation will be clearly stated in the record to support the date and times weights are taken. All staff will receive training to ensure compliance Ongoing

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W 463	Continued From page 14 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the physician had been included in the prescribing of each modified or special diet for two of three clients in the sample. (Clients #1 and #3) The finding includes: a. On August 26, 2009 beginning at 10:30 a.m., review of Client #1's July 2009 and August 2009 Medication Administration Records (MARs) revealed that she had begun receiving 4 cans of Jevity 1.5 bolus feeding on July 9, 2009. This was an increase from 3 cans daily, as recommended by the nutritionist on a July 3, 2009 consultation. Nurse progress notes dated July 9, 2009 and July 10, 2009 observed in Client #1's medical chart also documented the increase in bolus feeding to 4 cans daily. However, review of the physician's orders that were prepared by the pharmacy (effective June 1, 2009, "valid for 120 days") listed 3 cans of Jevity 1.5 daily and did not reflect any changes made to the amount ordered since then. In addition, there was no evidence of a corresponding telephone order. b. Similarly, Client #3 had a physician's order dated July 3, 2009 to "Provide eight ounces Resource 2.0 (480 cal) once a day with medication pass for nutritional supplement." On August 11, 2009, the nutritionist recommended a doubling of the Resource 2.0 (480 cal), increase it to twice a day. Her August 2009 MAR reflected that she had been receiving the Resource twice daily. However, there was no evidence of a corresponding physician's order for the increase.	W 463	W463 This Standard will be met as evidenced by: The RN/LPN will ensure that that the physician is informed and prescribes orders in accordance to the specified needs of the individuals. The RN/LPN will inform the physician of all related information pertaining to individuals specialized diets to include but not limited to; food preferences, laboratory reports, intake.... The RN/LPN will ensure that physician orders are consistent with the Medication Administration records. The RN will monitor for ongoing compliance.	9-11-09 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/26/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		

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I 000	INITIAL COMMENTS The Health Regulation Licensing Administration (HRLA) received a report via e-mail on August 24, 2009, from University Legal Services (ULS) monitoring team. Attached to the e-mail was a report dated August 20, 2009 of an onsite visit completed by their nurse consultant who alleged that three class members were noted with significant deficiencies, as described below: (1) Three Class members experienced significant weight fluctuations in 2009. Due to the nature of this complaint, on August 26, 2009 two HRLA surveyors initiated an onsite investigation. The findings of the investigation were based on observations in the group home, interviews with direct care and administrative staff, and the review of the investigative and administrative records. As a result of the investigative findings, the state agency determined that the facility was not in compliance with standard level requirements, as evidenced by deficiencies cited throughout this report. The allegation involving the three class members experiencing significant weight fluctuations in 2009 was substantiated.	I 000		
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to document that each employee received effective training required for accurate assessment of the residents' weights, for four of	I 223	1223 3510.4 This Statute will be met as evidenced by; Reference response to W192 and W331.	9.24.09 ongoing

Health Regulation Administration

Nancy Bramble

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

TITLE DRS

(X6) DATE 10/12/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 223	Continued From page 1 the seven residents residing in the facility. (Residents #1, #2, #3 and #4) The findings include: The August 20, 2009 complaint included an allegation that "weight loss concerns" had been identified in this facility for some of the residents. The complaint included a statement from their nurse consultant that "According to the nutritionist, the reasons for the weight fluctuation" were "not clear in many cases." The August 26, 2009 investigation confirmed the allegation. On August 26, 2009 beginning at 8:45 a.m., interviews with an LPN and the house manager revealed that weight variations had been documented for four of the seven residents, starting in May 2009. They indicated that the agency had suspected that weights recorded by a weekend nurse in early 2009 had not been measured accurately. Further interview revealed that the supervisory nursing staff had provided training to the nursing staff on the correct procedures for measuring residents' body weights. The date/time of the training, however, was unclear from the interviews. Subsequent review of the in-service training records failed to show evidence of said training on weighing techniques. The supervisory RN was unavailable at the time for interview. No additional information was provided; therefore, a chronological history of nurse training on the facility's weighing protocol and procedures could not be verified.	I 223	1401 3520.3 **This Statute will be met as evidenced by:** Reference response to W217 and W331 and W463.	9-24-09 ongoing
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis	I 401		

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I 401	Continued From page 2 and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to provide nursing, nutrition and/or physician services timely to meet the residents' needs, for four of the four residents in the sample. (Residents #1, #2, #3 and #4) The findings include: 1. The facility's nursing services failed to establish systems to provide accurate weight monitoring and identify services in accordance with the needs of Residents #1, #2, #3 and #4. The August 20, 2009 complaint included an allegation that "weight loss concerns" had been identified in this facility for some of the residents. The complaint included a statement from their nurse consultant that "According to the nutritionist, the reasons for the weight fluctuation" were "not clear in many cases." The August 26, 2009 investigation confirmed the allegation. 1. On August 26, 2009 at 8:45 a.m., interview with the day nurse (an interim LPN) confirmed that weight variations had been an agency concern. The supervisory RN was unavailable for interview at the time; however, interview with an interim LPN (who normally worked in another of the agency's facility's) confirmed that only nurses weighed the residents. She indicated that systems had been implemented to address the weight concerns.	I 401		

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I 401	Continued From page 3 On August 26, 2009 at 8:45 a.m., review of a Monthly Weight Chart revealed the nurses documented the weights of all eight residents on the same form. Further review of the chart revealed that four of the residents had experienced a change of 5 pounds or greater within a one-month period. Additional review revealed that the facility's nursing staff failed to implement instructions that were included on the chart, as follows: "reweigh within 24 hours if weight change is 5 pounds or greater (loss of gain)." The chart showed that nurses had re-weighed a resident within 24 hours in only one of the six instances, when they documented weight changes of 5 pounds or greater. Continued review of the chart, however, revealed the following: a. Resident #1's weight dropped from 176.6 pounds in May to 171.4 pounds in June (5.2 pounds); b. Resident #1's weight dropped again from 171.4 pounds to 166.4 pounds in July (5 pounds); c. Resident #1's weight then increased 5.2 pounds to 171.6 pounds in August. d. Resident #2's weight dropped 10.2 pounds from 103 pounds in May to 92.8 pounds in June 2009; and, e. Resident #3 weight dropped 10.6 pounds between April (114 pounds) and May 2009 (103.4 pounds). Review of the residents' records revealed no evidence that the women were re-weighed on any of those 5 occasions.	I 401		

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I 401	Continued From page 4 2. The Monthly Weight Chart in the nursing office showed that Resident #4 was weighed 83 pounds at some time in May 2009. The chart then showed that she was re-weighed that month and another weight (71.8 pounds) was also documented. There were no dates provided for either weighing; therefore, it could not be verified whether she had been re-weighed after 24 hours, in accordance with the instructions. 3. According to various staff, the agency's weighing policies and procedures had been updated in recent months; however, this assertion could not be verified, as follows: a. On August 26, 2009 at approximately 9:20 a.m., interview with the House Manager indicated that until approximately 2 or 3 months earlier, the residents had been weighed on the first Saturday of every month. This reportedly had changed whereby nurses now rotated the duty. At approximately 10:06 a.m., the interim LPN said the practice of weighing the residents on the first Saturday of the month was being implemented in the agency's facilities. The nurse indicated, however, that she was providing temporary coverage at the group home and was unable to verify the days the resident's were weighed. She agreed to seek the agency's current weighing policies. She was unable to locate said policies before the investigators left the facility that evening. On August 26, 2009 at 2:43 p.m., review of a document titled "Weekend Day Nurse Duties and Responsibilities" (not dated) revealed the following: "Weigh consumers on the third Saturday of each month. Document weight in the consumer's records. Notify physician of any abnormal weight gain or loss." There was no	I 401		

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I 401	Continued From page 5 evidence that this document had been implemented or reviewed. On August 26, 2009, 2:50 p.m., a Monthly Weight Chart was reviewed, which included the residents' weights for 2009. A typed entry at the top of the form documented "Reweight within 24 hours if weight change is 5 pounds or greater (loss or gain)." There was no evidence, however, that the residents were reweighed within 24 hours if the weight change was 5 pounds or greater (loss or gain), as previously mentioned 5. When interviewed by telephone on August 26, 2009, beginning at 4:06 p.m., the supervisory RN confirmed that agency nurses were to reweigh residents if/when there was a 5 pound or more change in weight. She referred investigators to the Director of Nursing for the actual policy. This policy however was not presented for review when requested during the investigation. The existence of these policies was discussed during the exit teleconference held on August 27, 2009; however, no additional information was shared with HRLA. 4. There was no evidence that facility nursing services sought clarification and/or guidance from the primary care physician (PCP) after Resident #1's team disagreed with a nutritionist's recommendation, as follows: Resident #1 had been receiving 4 cans of Jevity 1.5 bolus feeding via g-tube since July 9, 2009. Record review on August 26, 2009 at 12:45 p.m. revealed a July 8, 2009 Nutritional Weight Evaluation and corresponding Mealtime/Tube Feeding Guidelines, initialed by the primary care physician (PCP), to increase from 3 bolus	I 401		

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I 401	Continued From page 6 feedings to 4 bolus feedings daily. At approximately 3:45 p.m., review of the resident's records revealed a July 23, 2009 Third Quarterly Nutrition Review in which the nutritionist documented the already-instituted increase to 4 bolus feeding daily. At 3:51 p.m., review of a QMRP Third Quarterly Review dated July 27, 2009 revealed that the interdisciplinary team (IDT) had met on July 24, 2009 and disagreed with the nutritionist's recommendation, as Resident #1 was "already above her ideal body weight." The attached signature sheet indicated that neither the nutritionist nor the supervisory RN had been in attendance at the July 24, 2009 team meeting. The records failed to show evidence that anyone had contacted the nutritionist or sought input from the PCP to inform them of the IDT's recommendation. Although the IDT did not accept the nutritionist's recommendation to increase Resident #1's tube feeding to 4 cans daily, the medication administration record (MAR) for August 2009 documented that she continued receiving 4 cans daily, yet there was no corresponding order from the PCP. When interviewed by telephone beginning at 4:04 p.m., the supervisory RN stated that if the PCP initialed a document, such as the nutritionist's reviews, that meant that he had concurred with the nutritionist's recommendations. II. The facility failed to ensure nutritional assessments identified the current caloric needs for Resident #2, #3 and #4 . A. On August 26, 2009 at 8:45 a.m., interview with direct support staff revealed that Resident #3 was totally dependent on staff for feeding and	I 401		

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I 401	Continued From page 7 received a pureed diet. Interview the interim LPN at 9:17 a.m. revealed Resident #3 was prescribed a pureed, low fat, low cholesterol, added fiber, nectar thick liquids diet. The nurse indicated that with the addition of a high calorie nutritional supplement twice daily to her diet, the resident's weight was essentially stable. On August 26, 2009 at 9:20 a.m., review of the facility's monthly weight record documented that Resident #3 experienced an 11-pound weight loss from April 2009 (114 pounds) to May 2009 (103 pounds). The nurse indicated that the resident's weight loss/discrepancy was thought to have been due to an error in the weighing technique used by the assigned nurse. The interim nurse also indicated that although specific nursing staff had been assigned to weigh the residents, it was the responsibility of the facility's primary nurse to monitor the residents' health status, including changes in body weights. Further interview with the interim LPN, however, failed to determine when the nutritionist was informed of Resident #3's weight loss. Record review on August 26, 2009 at 9:37 a.m. did reveal a Nutritional Weight Evaluation dated July 3, 2009 for Resident #3. Although this evaluation documented the resident's weights of 114 pounds in April, 103.4 pounds in May, 102 pounds in June and 101.2 pounds in July, there was no evidence these weights were reviewed by the nutritionist until July 3, 2009. The facility's monthly Weight Chart showed a continued decline in weight to 100.8 pounds in August 2009. The July 3, 2009 Nutritional Weight Evaluation revealed the following statement: Resident #3's "May weight reflects a significant loss of 11.6 pounds/10% in 30 days. Her weight since then	I 401		

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I 401	Continued From page 8 exhibits a downward trend. Her weight remains at the lower half of her Healthy Weight Range. She is prescribed a regular portion diet to maintain her weight. Her appetite is good and no known changes in her care that can be attributed to her weight loss ....Since her weight is at the lower half of her body weight a nutritional supplement is recommended to prevent further weight loss." Review of Resident #3's record on August 26 at 9:45 a.m., revealed a telephone physician's orders dated July 3, 2009, to "Provide eight oz Resource 2.0 (480 calories) once a day with Medication Pass for nutritional supplement." Review of Resident #3's Third Quarterly Nutritional Review dated August 11, 2009 (for May, June, and July 2009) on August 26, 2009 at 10:09 a.m. revealed that her weight continued to trend downward. In the August 11, 2009 review, the nutritionist recommended to "Increase Resource 2.0, eight ounces to 2 x day with medication pass, due to continued weight loss." Documentation on Resident #3's August 2009 MAR revealed that she began receiving two 8 ounces of Resource 2.0 daily on August 11, 2009. Although high calorie nutritional supplements had been recommended for the resident to prevent weight loss, the resident continued to experience a gradual decrease in weight. Additionally, there was no evidence that Resident #3's specific caloric needs had been reassessed after her weight loss began in May 2009. E. On August 26, 2009 at 8:50 a.m., interview with direct support staff revealed that Resident #2 was totally dependent on staff for feeding and received a pureed diet with supplemental feeding to prevent her from losing weight. Interview the interim LPN at 11:02 a.m. revealed Resident #3	I 401		

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I 401	Continued From page 9 was prescribed a pureed diet and a high calorie nutritional supplement once a day to prevent weight loss. She further indicated that although the resident had lost some weight, her weight had essentially stabilized. Record review on August 26, 2009 at 9:40 a.m. revealed a chart on which Resident #2's 2009 weights were recorded. The chart documented the resident's weight loss of 11 pounds from 103 pounds (May 2009) to 92 pounds (June 2009). Their monthly weight chart documented a weight of 93.8 pounds in July 2009. The July 2009 medication administration record (MAR) revealed a reweigh of 91.4 pounds on July 27, 2009. A monthly weight of 91.6 pounds was recorded on the weight chart for August 2009. On August 26, 2009 at 10:20 a.m., review of the July 3, 2009 nutritional evaluation revealed the following statement: Resident #2's "June weight reflects a 10.2 pound/10% significant weight loss in thirty days. Her weight has stabilized since then and is at the lower half of her Healthy Weight Range. She is prescribed a regular portion diet to maintain her weight. There are no other changes in her care that can be attributed to her weight loss. Her appetite is good.....Since her weight is at the lower half of her Healthy Weight Range, a nutritional supplement is recommended." Review of the resident's physician's orders on August 26, 2009 at 10:40 a.m. showed that Resource 2.0 (480 calories) 8 oz daily was prescribed on July 3, 2009 in accordance with the nutritionist's recommendation on that date. On July 7, 2009, the PCP further ordered "Monitor weights weekly and record." However, review of the facility's aforementioned Monthly Weight	I 401		

PRINTED: 09/29/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0048	A. BUILDING _____ B. WING _____	C 08/26/2009

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 10 Chart and the resident's Weight/Blood Pressure Record showed that her weight continued to gradually decrease. Subsequent review of the June 2009 QMRP Monthly Progress Notes dated July 13, 2009 revealed Resident #2's "weight shows a big discrepancy this month. Her current weight is 92 pounds which shows a weight loss of almost 12 pounds. However, she continued to be within her healthy weight range (85 to 111 pounds) Consult with the PCP, Nurse and nutritionist to re-evaluate Resident #2..... Day nurse to assess scale to ensure accuracy, and redo her weight. Meal time protocol is in place..monitor closely and report any significant change to the nutritionist immediately. Although the high calorie nutritional supplement had been provided as recommended by the nutritionist and prescribed by the PCP, there was no evidence that Resident #2's caloric requirement had been reassessed after her June weight loss/discrepancy was identified. C. On August 26, 2009 at 9:55 a.m., interview with direct support staff revealed Resident #4 was prescribed a pureed diet and a nutritional supplement to help her gain weight. At 10:39 a.m., interview with the interim LPN indicated that the resident had lost some weight, however her weight had stabilized since she started receiving more calories. Further interview with the interim LPN, however failed to verify when the nutritionist was informed of Resident #4's weight loss. On August 26, 2009 at 10:20 a.m., review of the facility's monthly weight record revealed that Resident #4 weighed 76.2 pounds in April 2009. The same weight chart showed that Resident #4	I 401		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0048	A. BUILDING _____ B. WING _____	C 09/28/2009

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

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I 401	Continued From page 11 weighed 83 pounds at sometime in May 2009. A reweight later in May showed another weight (71.8 pounds) was documented. The resident's Weight/Blood Pressure Record revealed weights of 76.2 pounds in April 2009, 72 pounds in May, and 68.2 pounds in June 2009. The nurse indicated that the resident's initial weight change was thought to have been due to an error in the weighing technique used by the assigned nurse. Further interview with the nurse indicated that although specific nursing staff had been assigned to weigh the residents, it was the responsibility of the facility's primary nurse to monitor the residents' health status, including changes in body weights. On August 26, 2009 at 3:00 p.m., Resident #4's Third Quarterly Nutritional Review (for March, April, May 2009) dated June 25, 2009, documented the resident's March 2009 (75.4 pounds) to May 2009 (71.8 pounds) weights, reflecting a 3.6 pound loss during this period. The nutritionist recommended that the resident continue to be provided a low fat/cholesterol, added fiber, pureed tied with 8 ounces Boost Plus after dinner as prescribed. The review of the monthly Qualified Mental Retardation Professional summary revealed "Consult with nutritionist if weight loss/gain of 5 pounds is indicated within one month or if weight loss trend is indicated over 2-3 months." The record review, however, failed to verify that the nutritionist was aware of the weight changes/discrepancies or had assessed them until July 3, 2009. Review of the Nutritional Weight Evaluation dated July 3, 2009 on August 26, 2009 at 3:17 p.m. revealed the resident's weight loss from 76.2 pounds in April 2009 to 68 pounds in June 2009. The July 3, 2009 nutritional evaluation revealed	I 401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0048	A. BUILDING _____ B. WING _____	C 08/26/2009

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

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I 401	Continued From page 13 recommended by the nutritionist on a July 3, 2009 consultation. Nurse progress notes dated July 9, 2009 and July 10, 2009 observed in Resident #1's medical chart also documented the increase in bolus feeding to 4 cans daily. However, review of the physician's orders that were prepared by the pharmacy (effective June 1, 2009, "valid for 120 days") listed 3 cans of Jevity 1.5 daily and did not reflect any changes made to the amount ordered since then. In addition, there was no evidence of a corresponding telephone order. B. Similarly, Resident #3 had a physician's order dated July 3, 2009 to "Provide eight ounces Resource 2.0 (480 cal) once a day with medication pass for nutritional supplement." On August 11, 2009, the nutritionist recommended a doubling of the Resource 2.0 (480 cal), increase it to twice a day. Her August 2009 MAR reflected that she had been receiving the Resource twice daily. However, there was no evidence of a corresponding physician's order for the increase.	I 401		