

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

PRINTED: 09/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/04/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>The Health Regulation Licensing Administration (HRLA) received a report via email on September 1, 2009, from University Legal Services (ULS) monitoring team. Attached to the email was a report dated August 29, 2009, of an onsite visit completed by their nurse consultant who alleged that significant deficiencies were observed involving four class members, as described below:</p> <p>(1) Class member's fluid restriction program is not being implemented as ordered;</p> <p>(2) Class member's wheelchair does not provide her with adequate support; the status of her new wheelchair, ordered in April 2009, has been "pending" for months.</p> <p>(3) Staff are not implementing positioning protocols as ordered.</p> <p>(4) Staff persons are not adequately familiar with the class members' significant health risks;</p> <p>(5) Staff are not familiar with or implementing class members' behavioral support plans;</p> <p>(6) The home is not adequately staffed;</p> <p>(7) Staff are not implementing class members' physical therapy recommendations;</p> <p>(8) Class members are left awake in bed in the afternoon;</p> <p>(9) Staff has minimal meaningful interactions with class members;</p>	W 000	<p><i>Received 11/4/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE <i>11/4/09</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	<p>Continued From page 1</p> <p>(10) Nursing staff failed to ensure that the physician was made aware of Client #1 receiving far more fluids than ordered;</p> <p>(11) Staff are not aware that the class members' medical records contained health care management plans (HCMP); Staff had not received training on the HCMPs;</p> <p>(12) A medical record does not indicate whether a class member's primary care physician agreed with the recommendations and whether a second GI consultation is indicated;</p> <p>(13) Nursing staff failed to continue documenting and tracking the amount of edema daily for a class member;</p> <p>Due to the nature of this complaint, on September 3, 2009, three HRLA surveyors initiated an onsite investigation. The findings of the investigation were based on observations in the group home and day program, interviews with the facility and day program staff, review of the ULS findings, and review of facility's records, including unusual incident reports, investigative and administrative records.</p> <p>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 throughout this report. The following six out of the twelve concerns identified by ULS were substantiated as follows:</p> <p>(a) The facility's nursing services failed to ensure the physician's recommendation to decrease Client #2's fluid intake from 1200 cc to 1000 cc was implemented;</p>	W 000			

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W 000	Continued From page 2 (b) The facility's nursing services failed to ensure Client #2 received the appropriate amount of fluids as ordered by the physician and failed to ensure the physician was made aware; (c) The facility's QMRP failed to address Client #3's assessed physical therapy needs (specifically, repositioning every hour); (d) The facility nursing staff failed to ensure all staff had received training on the clients Health Management Care Plan (HMCP). (e) The facility failed to ensure Client #3's wheelchair headrest was ordered; and (f) Nursing staff failed to continue documenting and tracking Client #2's edema daily.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that outside services met the needs of each client, for one of five clients in the investigation. (Client #1) The finding includes: Cross refer to W 331.3. The facility's nursing services failed to ensure Client #2 received the appropriate amount of fluids as ordered by the physician and failed to ensure the physician was made aware of the error in the amount actually	W 120	W120 This Standard will be met as evidenced by: Cross reference response to W331.3. Client #1's fluid recommendation has been implemented as ordered by physician. An in-service training has been completed with the day program. In addition, a fluid intake sheet and a measuring cup is now being used at the home and at the day program which clearly outlines the amount of fluid client #1 should be receiving. QMRP will revisit the day program to ensure compliance with the fluid intake as ordered by the physician.	9.8.09 ongoing

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W 120	Continued From page 3 received.	W 120		
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENT'S</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries to determine neglect or mistreatment for one of the seven clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>On September 4, 2009 beginning at approximately 1:15 p.m., review of incident reports and corresponding investigations revealed that on April 24, 2009, Client #4 sustained an injury to her shoulder while receiving x-rays at a hospital. Specifically, the hospital sent a report of the findings (report dated April 27, 2009) in which the hospital wrote: "the shoulder appears to have dislocated at some point during the course of the radiographic evaluation."</p> <p>Review of the corresponding investigation report (report not dated) revealed that the investigator interviewed a residential LPN and their Director of Nursing. The interviewer also documented having reviewed the radiology report, the incident report and Client #4's habilitation and medical records.</p> <p>Further review of the facility's investigation report revealed that while it identified the location where the injury was thought to have happened (hospital radiology clinic), it failed to indicate a cause.</p>	W 154	<p>W154 This Standard will be met as evidenced by:</p> <p>Client #4 was seen for follow up with Orthopedic doctor which indicated that she did not sustain an injury to her shoulder as previously reported by the technician. She was also seen for second opinion and follow-up x-rays which also confirmed that client #4 did not sustain injury to her shoulder as reported. Director of Residential or designee will continue to provide on-going training to QMRP's and/or designated investigators on incident investigation and reporting process.</p>	9-7-09 completing

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W 154	Continued From page 4 There was no evidence that the facility sought to determine whether facility and/or hospital staff provided Client #4 supports and assistance in the manner prescribed in her plan. The investigation did not reflect any interviews conducted with facility staff who accompanied her to the hospital that day, nor was there evidence that anyone from the hospital had been interviewed about the procedures used while Client #4 was being X-rayed.	W 154		
W 156	At approximately 1:45 p.m., the Assitant Director of Residential Services stated that she did not have any additional information regarding the investigation into Client #4's dislocated shoulder. 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 failed to document having reported the results of all investigations of injuries of unknown origin to the administrator within five working days of the incident, for one of the seven clients residing in the facility. (Client #4) The finding includes: Cross-refer to W154. On September 4, 2009 beginning at approximately 1:15 p.m., review of incident reports and corresponding investigations revealed that on April 24, 2009, Client #4 sustained an injury to her shoulder while receiving	W 156	W156 This Standard will be met as Evidenced by: The QMRP conducting the investigation no longer works for the company. All QMRP _s have received training on incident reporting and investigation process. Additional corrective actions will be taken as needed to ensure ongoing compliance with this standard. The position of Incident Management Coordinator is currently being advertised. Incident Management Coordinator will further ensure that incidents are reviewed, investigated, filed and submitted to administrator and regulatory agencies in accordance with company policies and procedures. Routine file reviews will be conducted and follow-up actions completed in accordance to the findings.	9.10.09 ongoing

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W 156	Continued From page 5 x-rays at a hospital. The facility's administrators were made aware of the injury on May 1, 2009. However, review of the corresponding investigation report revealed that it was not dated. There was no information contained in the report's text that indicated how long it took to complete the investigation, once the dislocated shoulder was discovered. There was no additional information provided that could verify that the investigation findings were reported back to the administrator within 5 working days.	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 interviews and review of staff in-service training records, the facility failed to ensure 2 of the 4 direct support staff on duty had received training on the clients' Health Management Care Plans (HMCPs) and seizure management precautions. The findings include: On September 3, 2009 beginning at 10:41 a.m., interview with direct support staff, followed by a review of staff training records (beginning at 12:05 p.m.) revealed that 2 of the 4 staff who were on duty when the nurse consultant visited the facility on Saturday, August 29, 2009 had not received healthcare-related training, as follows: 1. At approximately 8:25 a.m., interview with Staff #1 revealed that she had started working in the facility on June 15, 2009. She replied "yes"	W 192	W192 This Standard will be met as Evidenced by: Orientation training modules are currently being reviewed and revised to include additional information related to the health care needs of the individuals served. Competency tests are included as a part of the revision process. All staff in the home has received training on health management care plan, Hygiene practices and seizure precautions. Also the medical team and QMRP will provide on-going instruction and feedback to ensure that staff can demonstrate the skills and techniques associated with the desired outcomes outlined in the HMCP. QMRP/LPN/RN will be expected to provide training as needed. Record of such training will be filed in Training book.	9.24.09 Ongoing

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W 192	<p>Continued From page 6</p> <p>when asked if she had been trained on the clients' HMCPs. She stated that a "lady came last week... Saturday." When she could not recall the lady's name, she turned to Staff #2 who was working nearby and asked her. Staff #2, who had been working there that day, cited the name of the ULS nurse consultant who had visited the facility. Staff #2 quickly added that the visitor (ULS nurse consultant) "did not do training."</p> <p>At approximately 11:05 a.m., Staff #1 stated that she had not received training on seizure precautions; adding however, that she had some prior knowledge of the subject. When asked if she had received training on providing hygiene and toileting care to reduce the risk of urinary tract infections, she replied that staff should "give them plenty of fluids." Subsequent review of the in-service training records showed no documented evidence that she had received training in those areas. The next morning, review of the staffing pattern confirmed that Staff #1 had been on duty when the ULS nurse consultant was in the facility on Saturday, August 29, 2009.</p> <p>2. Similarly, at approximately 8:25 a.m., interview with Staff #2 revealed that she had not received training on the clients' HMCPs or on seizure precautions. Three of the five clients in the sample had current or past histories of seizures. Staff #2 indicated that she had been employed in this facility for approximately 1 year and 2 months. Subsequent review of the in-service training records failed to show evidence that she had received training on the clients' HMCPs.</p>	W 192		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p>	W 331		<p>9/6/09 orginc</p>

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W 331	<p>Continued From page 7</p> <p>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 health care monitoring and identify services in accordance with clients' needs, for three of five clients being investigated. (Clients #2, #3, and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's nursing services failed to ensure the physician's recommendation to decrease Client #2's fluid intake from 1200 cc to 1000 cc was implemented. <p>Review of Client #2's medical records on September 3, 2009, beginning at 3:37 p.m., revealed an annual medical evaluation dated June 21, 2009. Further review revealed the medical evaluation reflected that Client #2's sodium levels remained low despite a 1200 cc fluid restriction and should be lowered to 1000 cc a day. Continued review of the client's records at approximately 3:40 p.m., revealed an interim physician order dated August 29, 2009. The order documented to discontinue Client #2's 1200 cc fluid restriction and to begin Client #2's on 1000 cc fluid restriction a day.</p> <p>Review of the nurse's progress notes dated August 29, 2009, on September 3, 2009 at approximately 3:50 p.m. further verified to discontinue Client #2's 1200 cc fluid restriction and to begin Client #2's on 1000 cc fluid restriction a day.</p> <p>Review of Client #2's lab reports on September 4,</p>	W 331	<p>W 331</p> <p>This Standard will be met as Evidenced by:</p> <ol style="list-style-type: none"> Client #1's fluid intake was modified during client #1's annual review. The nurse present at the time of the meeting is no longer with the company. The facility RN will ensure that the nursing staff receive additional training and oversight to ensure that recommendations made by the physician are implemented. RN will review recommendations and provide follow-up with the nursing staff assigned to the home. Nurse/RN will clarify recommendations as needed and make day program staff aware of all orders in a timely manner. Also reference response to W189. 	<p>9609 ongoing</p>
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W 331	<p>Continued From page 8</p> <p>2009, at approximately 1:50 p.m., revealed her sodium levels should reference between (135 - 147 MEQ/L). Further review of the client's labs revealed the following sodium levels:</p> <p>a. August 18, 2009 - 131 MEQ/L b. May 26, 2009 - 130 MEQ/L c. April 23, 2009 - 130 MEQ/L d. December 10, 2008 - 133 MEQ/L</p> <p>Continued review of the aforementioned report revealed the primary care physician had been made aware of the levels and no additional orders were identified.</p> <p>On September 4, 2009, at approximately 10:30 a.m., interview with LPN #1 acknowledged that the physician's recommendation to decrease Client #2's fluid restriction from 1200 cc to 1000 cc a day was not implemented timely.</p> <p>2. The facility's nursing services failed to ensure day program was made aware of the change in Client #2's fluid restriction timely.</p> <p>During an onsite visit to Client #2's day program on September 3, 2009, at 12:42 p.m., interview with the day program's case manager (CM) revealed that the day program received a faxed interim physician order (PO) for the client dated August 29, 2009 on September 3, 2009 from the group home. The order stated to discontinue 1200 cc fluid restriction and start the client on 1000 cc a day. This information was verified by the day program's director of nursing (DON) on September 3, 2009 at 1:00 p.m. The DON stated that she would immediately call Client #2's group home to inquire about training for the new mealtime protocol.</p>	W 331	<p>2. DON will review current policies and procedures/protocols and revise as needed to ensure ongoing compliance with this standard. Additional training will be conducted for LPN staff to include but not limited to; consistent ongoing communications, timely follow-up, visitations to day program and verifying receipt of information. The RN will monitor nursing practices and provide additional corrective actions as needed.</p>	9.14.09 ongoing	

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W 331	<p>Continued From page 9</p> <p>Interview with LPN #1 on September 4, 2009, at approximately 10:30 a.m. acknowledged that Client #2's new orders were faxed to the day program on September 3, 2009. At the time of the investigation, the facility failed to ensure the day program was notified timely of the orders to decrease Client #2's fluid intake.</p> <p>3. The facility's nursing services failed to ensure that Client #2's edema to her right foot was documented and that the physician was made aware.</p> <p>Interview with LPN #2 on September 4, 2009, at 2:24 p.m. revealed that he had worked the day of August 29, 2009. Further interview with LPN #2 revealed that he recalled having assessed Client #2's foot with the ULS nurse consultant on August 29, 2009. LPN #2 stated that Client #2 had 1+ pitting edema in her right foot. When asked if he had documented the edema in his nursing notes or on the MAR, LPN #2 stated that he "was not sure."</p> <p>Review of the nursing notes on September 4, 2009, at approximately 2:30 p.m., dated August 29, 2009, and review of the current MAR revealed LPN #2 did not document edema observed on Client #2's right foot.</p> <p>On September 4, 2009, at approximately 3:50 p.m. interview with LPN #1 revealed that when edema is observed, nurses should document it in the nursing notes and on the MAR. Further interview with LPN #1 revealed the primary care physician (PCP) should be notified. At the time of the investigation, the facility failed to provide evidence that Client #2's edema had been</p>	W 331	<p>3. Client #2's edema is appropriately documented on the MAR. The RN will provide additional training on documentation of pertinent health related concerns such as edema until resolved. The nurse is expected to document observations and assessments in the Nursing Progress notes on a daily basis.</p>	9-8-09 ongoing

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W 331	<p>Continued From page 10 documented as required.</p> <p>4. The facility's nursings services failed to address Client #3's assessed physical therapy needs (specifically, repositioning every hour).</p> <p>On September 3, 2009 at 3:10 p.m., interview with a direct support staff person revealed that all clients were repositioned every 2 hours. This was repeated by another direct support staff person during her interview the next morning at approximately 9:58 a.m.</p> <p>On September 4, 2009 beginning at 12:16 p.m., review of Client #3's physical therapy assessment dated June 4, 2009 revealed that the PT had recommended that she be repositioned every hour. Subsequent review of her Individual Support Plan (ISP) dated June 22, 2009 and Health Management Care Plan dated June 19, 2009 revealed that both plans had not been updated to reflect the PT's recommendation. There were no QMRP reports or notes available for review for June 2009 in Client #3's record. Review of the signature sheet for the June 22, 2009, ISP meeting revealed that the PT had not been in attendance. The QMRP and Supervisory RN were unavailable for interview during the investigation and the Assistant Residential Director stated that she was previously unaware of the PT recommendation. There was no evidence that the PT's recommendation for hourly repositioning had been brought to the interdisciplinary team's (IDT) attention by the QMRP.</p> <p>The PT came to the facility during the September 4, 2009 Exit conference. He stated that the recommended hourly repositioning was specific to</p>	W 331	<p>4. The QMRP is no longer employed with company. The repositioning schedule has been modified to reflect the recommendations outlined by the Physical Therapist. Staff training has been completed and adherence to the schedule continues to be monitored by the LPN staff/and Managers.</p>	9.11.09 ongoing

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4516 EDSON PLACE, NE WASHINGTON, DC 20019	
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W 331	<p>Continued From page 11</p> <p>Client #3 and her needs. He did not recall receiving any inquiries from the QMRP or others on the IDT regarding the recommendation during the meeting or in the 2 months since then. He reiterated his concern for Client #3's skin integrity and the need for hourly repositioning.</p> <p>It should be noted that staff documentation on Client #3's repositioning chart indicated that she was in her wheelchair for the 6 hours between 8:00 a.m. - 2 p.m. on Saturdays and Sundays throughout the months of June, July and August 2009.</p> <p>There was no evidence that the facility monitored the client's repositioning chart to ensure staff adherence to her repositioning schedule.</p> <p>5. The facility's nursing services failed to ensure that Client #4 received eight cups of fluid daily as prescribed by the nutritionist.</p> <p>Observation on September 3, 2009 at 6:48 a.m., revealed Client #4 drinking milk and juice.</p> <p>Review of Client #4's mealtime protocol dated September 14, 2008, on September 3, 2009, at approximately 11:30 a.m., revealed staff should provide at least eight cups of fluid daily. Review of Client #4's fluid intake sheets dated May 2009, through August 2009 indicated that the client consumed four to six cups of fluid daily. Further review of Client #4's records revealed a health management care plan dated May 20, 2009 states staff should provide six to eight cups of fluids if not contraindicated.</p> <p>Interview with the License Practical Nurse on</p>	W 331	<p>5. The Director of Nursing and RN's have conducted several trainings on adherence of adequate fluid intake and documentation of fluid intake and staff supervisions to ensure fluids are offered and given as recommended. RN will implement additional corrective actions as warranted for staff who fail to adhere to the expectations of performance and best practices. The RN will monitor fluid intake records to ensure ongoing compliance and follow-up.</p>	9-10-09 ongoing

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W 331	Continued From page 12 September 4, 2009, at approximately 2:00 p.m., confirmed that the HMCP recommended six to eight cups of fluids daily. Additional interview confirmed that Client #4's fluids intake sheet indicated that she consumed four to six cups of fluids daily. At the time of the investigation, it could be determined the amount of fluids Client #4's was prescribed.	W 331			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by. Based on observations, interviews and record review, the facility failed to furnish and maintain in good repair adaptive equipment, for one of the five clients included in the investigation. (Client #3) The findings include: 1. Client #3 was observed seated in her wheelchair on September 3, 2009 between 6:29 a.m. - 8:30 a.m. The headrest was centered on the back of the wheelchair, but the rod supporting it was angled to the left. Prior to breakfast, the client had her head positioned outside of the headrest. Her head laid at a sharp angle towards the left, resting against her left shoulder. The headrest was above/behind her head. Through most of the breakfast meal, she kept her head in the headrest, although on a few occasions (7:24	W 436	W436 This Standard will be met as Evidenced by: Review of client #3's record indicates that the PT recommendation for a molded seat was completed as ordered by the vendor. Client #3's head rest was later adjusted by the PT to provide proper support. The QMRP will continue to follow-up and document the status of client #3's adaptive equipment. QMRP will also inform the DDS Service Coordinator and request assistance as needed to ensure timely completion of repairs.	9-10-09 ongoing	

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W 436	<p>Continued From page 13</p> <p>a.m., 7:45 a.m. and 7:47 a.m.) she maneuvered her head back out of it and down against her shoulder. At those times, staff repositioned her head upright, in accordance with her mealtime protocol (dated June 16, 2008) that was on the table.</p> <p>On September 4, 2009 beginning at approximately 12:16 p.m., review of Client #3's physical therapy (PT) records revealed that the PT recommended a new custom-molded seating system and headrest for her in November 2008. Measurements for her new seating system were taken on April 22, 2009 and according to the house manager, the new seating was installed in the wheelchair on August 27, 2009 (5 months later). The house manager further indicated that the wheelchair technicians did not deliver the headrest, for reasons unknown. Review of the August 27, 2009 delivery ticket confirmed that the headrest was not delivered.</p> <p>The physical therapist came into the facility during the September 4, 2009 Exit conference. Interview with the PT confirmed that he had recommended a new headrest 10 months earlier. The current headrest was attached to the back of the wheelchair (Center). As such, it was severely angled and did not provide the necessary support. He wanted a new headrest mounted towards the left side of the wheelchair; this would prevent her head from resting against her shoulder.</p> <p>The September 2, 2009 complaint included an allegation that the headrest on Client #3's wheelchair did not properly support her head. The client reportedly kept her head in the headrest only while being fed. Otherwise, she held her head angled to the left and against her</p>	W 436		

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W 436	Continued From page 14 shoulder. In addition, it was alleged that Client #3 had not received a new, specially-molded wheelchair, as recommended by her physical therapist.	W 436		
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1 000	<p>INITIAL COMMENTS</p> <p>The Health Regulation Licensing Administration (HRLA) received a report via email on September 1, 2009, from University Legal Services (ULS) monitoring team. Attached to the email was a report dated August 29, 2009, of an onsite visit completed by their nurse consultant who alleged that significant deficiencies were observed involving four class members, as described below:</p> <p>(1) Class member's fluid restriction program is not being implemented as ordered;</p> <p>(2) Class member's wheelchair does not provide her with adequate support; the status of her new wheelchair, ordered in April 2009, has been "pending" for months.</p> <p>(3) Staff are not implementing positioning protocols as ordered.</p> <p>(4) Staff persons are not adequately familiar with the class members' significant health risks;</p> <p>(5) Staff are not familiar with or implementing class members' behavioral support plans;</p> <p>(6) The home is not adequately staffed;</p> <p>(7) Staff are not implementing class members' physical therapy recommendations;</p> <p>(8) Class members are left awake in bed in the afternoon;</p> <p>(9) Staff has minimal meaningful interactions with class members;</p> <p>(10) Nursing staff failed to ensure that the</p>	1 000		

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

TITLE
 DRS

(X6) DATE
 10/19/09

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1 000	<p>Continued From page 1</p> <p>physician was made aware of Client #1 receiving far more fluids than ordered;</p> <p>(11) Staff are not aware that the class members' medical records contained health care management plans (HCMP); Staff had not received training on the HCMPs;</p> <p>(12) A medical record does not indicate whether a class member's primary care physician agreed with the recommendations and whether a second GI consultation is indicated;</p> <p>(13) Nursing staff failed to continue documenting and tracking the amount of edema daily for a class member;</p> <p>Due to the nature of this complaint, on September 3, 2009, three HRLA surveyors initiated an onsite investigation. The findings of the investigation were based on observations in the group home and day program, interviews with the facility and day program staff, review of the ULS findings, and review of facility's records, including unusual incident reports, investigative and administrative records.</p> <p>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 throughout this report. The following six out of the twelve concerns identified by ULS were substantiated as follows:</p> <p>(a) The facility's nursing services failed to ensure the physician's recommendation to decrease Client #2's fluid intake from 1200 cc to 1000 cc was implemented;</p> <p>(b) The facility's nursing services failed to ensure</p>	1 000		

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1 000	<p>Continued From page 2</p> <p>Client #2: received the appropriate amount of fluids as ordered by the physician and failed to ensure the physician was made aware;</p> <p>(c) The facility's QMRP failed to address Client #3's assessed physical therapy needs (specifically, repositioning every hour);</p> <p>(d) The facility nursing staff failed to ensure all staff had received training on the clients Health Management Care Plan (HMCP).</p> <p>(e) The facility failed to ensure Client #3's wheelchair headrest was ordered; and</p> <p>(f) Nursing staff failed to continue documenting and tracking Client #2's edema daily.</p>	1 000		
1 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on interviews and review of staff in-service training records, 2 of the 4 direct support staff on duty had not received training on the residents' Health Management Care Plans (HMCPs) and seizure management.</p> <p>The findings include:</p> <p>On September 3, 2009 beginning at 10:41 a.m., interview with direct support staff, followed by a review of staff training records (beginning at 12:05 p.m.) revealed that 2 of the 4 staff who were on duty when the nurse consultant visited the GHMRP on Saturday, August 29, 2009 had not received healthcare-related training, as follows:</p>	1 222	<p>1222</p> <p>3510.3 Staff Training</p> <p>This Statute will be met as evidenced by:</p> <p>Reference responses to W192, W331, W436.</p>	<p>9-24-09 ongoing</p>

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I 222	<p>Continued From page 3</p> <p>1. At approximately 8:25 a.m., interview with Staff #1 revealed that she had started working in the GHMRP on June 15, 2009. She replied "yes" when asked if she had been trained on the clients' HMCPs. She stated that a "lady came last week... Saturday." When she could not recall the lady's name, she turned to Staff #2 who was working nearby and asked her. Staff #2, who had been working there that day, cited the name of the ULS nurse consultant who had visited the facility. Staff #2 quickly added that the visitor (ULS nurse consultant) "did not do training."</p> <p>At approximately 11:05 a.m., Staff #1 stated that she had not received training on seizure precautions; adding however, that she had some prior knowledge of the subject. When asked if she had received training on providing hygiene and toileting care to reduce the risk of urinary tract infections, she replied that staff should "give them plenty of fluids." Subsequent review of the in-service training records showed no documented evidence that she had received training in those areas. The next morning, review of the staffing pattern confirmed that Staff #1 had been on duty when the ULS nurse consultant was in the facility on Saturday, August 29, 2009.</p> <p>2. Similarly, at approximately 8:25 a.m., interview with Staff #2 revealed that she had not received training on the residents' HMCPs or on seizure precautions. Three of the five residents in the sample had current or past histories of seizures. Staff #2 indicated that she had been employed in this facility for approximately 1 year and 2 months. Subsequent review of the in-service training records failed to show evidence that she had received training on the residents' HMCPs.</p>	I 222		

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1401	Continued From page 4	1401		
1401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for three of five clients being investigated. (Clients #2, #3, and #4)</p> <p>The findings include:</p> <p>1. The facility's nursing services failed to ensure the physician's recommendation to decrease Client #2's fluid intake from 1200 cc to 1000 cc was implemented.</p> <p>Review of Client #2's medical records on September 3, 2009, beginning at 3:37 p.m., revealed an annual medical evaluation dated June 21, 2009. Further review revealed the medical evaluation reflected that Client #2's sodium levels remained low despite a 1200 cc fluid restriction and should be lowered to 1000 cc a day. Continued review of the client's records at approximately 3:40 p.m., revealed an interim physician order dated August 29, 2009. The order documented to discontinue Client #2's 1200 cc fluid restriction and to begin Client #2's on 1000 cc fluid restriction a day.</p> <p>Review of the nurse's progress notes dated</p>	1401		

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1401	<p>Continued From page 5</p> <p>August 29, 2009, on September 3, 2009 at approximately 3:50 p.m. further verified to discontinue Client #2's 1200 cc fluid restriction and to begin Client #2's on 1000 cc fluid restriction a day.</p> <p>Review of Client #2's lab reports on September 4, 2009, at approximately 1:50 p.m., revealed her sodium levels should reference between (135 - 147 MEQ/L). Further review of the client's labs revealed the following sodium levels:</p> <ul style="list-style-type: none"> a. August 18, 2009 - 131 MEQ/L b. May 26, 2009 - 130 MEQ/L c. April 23, 2009 - 130 MEQ/L d. December 10, 2008 - 133 MEQ/L <p>Continued review of the aforementioned report revealed the primary care physician had been made aware of the levels and no additional orders were identified.</p> <p>On September 4, 2009, at approximately 10:30 a.m., interview with LPN #1 acknowledged that the physician's recommendation to decrease Client #2's fluid restriction from 1200 cc to 1000 cc a day was not implemented timely.</p> <p>2. The facility's nursing services failed to ensure day program was made aware of the change in Client #2's fluid restriction timely.</p> <p>During an onsite visit to Client #2's day program on September 3, 2009, at 12:42 p.m., interview with the day program's case manager (CM) revealed that the day program received a faxed interim physician order (PO) for the client dated August 29, 2009 on September 3, 2009 from the group home. The order stated to discontinue 1200 cc fluid restriction and start the client on</p>	1401		

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1401	<p>Continued From page 6</p> <p>1000 cc a day. This information was verified by the day program's director of nursing (DON) on September 3, 2009 at 1:00 p.m. The DON stated that she would immediately call Client #2's group home to inquire about training for the new mealtime protocol.</p> <p>Interview with LPN #1 on September 4, 2009, at approximately 10:30 a.m. acknowledged that Client #2's new orders were faxed to the day program on September 3, 2009. At the time of the investigation, the facility failed to ensure the day program was notified timely of the orders to decrease Client #2's fluid intake.</p> <p>3. The facility's nursing services failed to ensure that Client #2's edema to her right foot was documented and that the physician was made aware.</p> <p>Interview with LPN #2 on September 4, 2009, at 2:24 p.m. revealed that he had worked the day of August 29, 2009. Further interview with LPN #2 revealed that he recalled having assessed Client #2's foot with the ULS nurse consultant on August 29, 2009. LPN #2 stated that Client #2 had 1+ pitting edema in her right foot. When asked if he had documented the edema in his nursing notes or on the MAR, LPN #2 stated that he "was not sure."</p> <p>Review of the nursing notes on September 4, 2009, at approximately 2:30 p.m., dated August 29, 2009, and review of the current MAR revealed LPN #2 did not document edema observed on Client #2's right foot.</p> <p>On September 4, 2009, at approximately 3:50 p.m. interview with LPN #1 revealed that when edema is observed, nurses should document it in</p>	1401		
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1401	<p>Continued From page 7</p> <p>the nursing notes and on the MAR. Further interview with LPN #1 revealed the primary care physician (PCP) should be notified. At the time of the investigation, the facility failed to provide evidence that Client #2's edema had been documented as required.</p> <p>4. The facility's nursings services failed to address Client #3's assessed physical therapy needs (specifically, repositioning every hour).</p> <p>On September 3, 2009 at 3:10 p.m., interview with a direct support staff person revealed that all clients were repositioned every 2 hours. This was repeated by another direct support staff person during her interview the next morning at approximately 9:58 a.m.</p> <p>On September 4, 2009 beginning at 12:16 p.m., review of Client #3's physical therapy assessment dated June 4, 2009 revealed that the PT had recommended that she be repositioned every hour. Subsequent review of her Individual Support Plan (ISP) dated June 22, 2009 and Health Management Care Plan dated June 19, 2009 revealed that both plans had not been updated to reflect the PT's recommendation. There were no QMRP reports or notes available for review for June 2009 in Client #3's record. Review of the signature sheet for the June 22, 2009, ISP meeting revealed that the PT had not been in attendance. The QMRP and Supervisory RN were unavailable for interview during the investigation and the Assistant Residential Director stated that she was previously unaware of the PT recommendation. There was no evidence that the PT's recommendation for hourly repositioning had been brought to the interdisciplinary team's (IDT) attention by the QMRP.</p>	1401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/04/2009
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4515 EDSON PLACE, NE WASHINGTON, DC 20019
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I 401	<p>Continued From page 8</p> <p>The PT came to the facility during the September 4, 2009 Exit conference. He stated that the recommended hourly repositioning was specific to Client #3 and her needs. He did not recall receiving any inquiries from the QMRP or others on the IDT regarding the recommendation during the meeting or in the 2 months since then. He reiterated his concern for Client #3's skin integrity and the need for hourly repositioning.</p> <p>It should be noted that staff documentation on Client #3's repositioning chart indicated that she was in her wheelchair for the 6 hours between 8:00 a.m. - 2 p.m. on Saturdays and Sundays throughout the months of June, July and August 2009.</p> <p>There was no evidence that the facility monitored the client's repositioning chart to ensure staff adherence to her repositioning schedule.</p> <p>5. The facility's nursing services failed to ensure that Client #4 received eight cups of fluid daily as prescribed by the nutritionist.</p> <p>Observation on September 3, 2009 at 6:46 a.m., revealed Client #4 drinking milk and juice.</p> <p>Review of Client #4's mealtime protocol dated September 14, 2008, on September 3, 2009, at approximately 11:30 a.m., revealed staff should provide at least eight cups of fluid daily. Review of Client #4's fluid intake sheets dated May 2009, through August 2009 indicated that the client consumed four to six cups of fluid daily. Further review of Client #4's records revealed a health management care plan dated May 20, 2009 states staff should provide six to eight cups of</p>	I 401		

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I 401	<p>Continued From page 9</p> <p>fluids if not contraindicated.</p> <p>Interview with the License Practical Nurse on September 4, 2009, at approximately 2:00 p.m., confirmed that the HMCP recommended six to eight cups of fluids daily. Additional Interview confirmed that Client #4's fluids intake sheet indicated that she consumed four to six cups of fluids daily. At the time of the investigation, it could be determined the amount of fluids Client #4's was prescribed.</p>	I 401		