

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted at this facility on November 16, 2009 through November 20, 2009. Due to systemic deficient practices identified during the 2008 recertification survey, as well as during an investigation conducted on August 26, 2009, the State Agency determined that the full survey process be used during the survey. A random sampling of four clients was selected from a residential population of eight females with varying degrees of mental retardation and physical disabilities.</p> <p>The results of the survey were based on observations in the home and at two day programs. Administrative, nursing and direct care staff interviews were conducted, as well as a review of clients' and administrative records; including a review of the unusual incident reports.</p> <p>Based on continued systemic deficiencies with its health care delivery, the facility was found not to be in compliance with the Conditions of Participation in Health Care Services and Governing Body.</p>	W 000		
W 102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>This CONDITION is not met as evidenced by. Based on observation, interview and record review the facility's governing body failed to maintain general operating direction over the facility. [See 104].</p>	W 102		

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

[Handwritten Signature]

TITLE
ORR

(X5) DATE
12/24/09

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.

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 102	Continued From page 1	W 102		
W 104	<p>The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure each client's health and safety. [See also W318]</p> <p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility's governing body failed to exercise general operating direction over the facility as evidenced by deficiencies cited below and those cited throughout this report.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The Governing Body failed to ensure its professional services dated all entries documented in the medical records. [See W114] The Governing Body failed to develop and implement an effective system for the oversight of services provided by contracted agencies. [See W120] The Governing Body failed to ensure nurse(s) utilized through an outside agency, were trained prior to providing care and services to the clients. [See W192] The Governing Body failed to ensure the staffing agency providing nursing services submitted all needed documentation to the group home as evidenced below: 	W 104	<p>W 102</p> <p>This Condition will be met as evidenced by:</p> <p>The Governing Body has taken steps to abate the systemic deficient practices. These steps include but are not limited to; hiring a physician as Medical Director; hired a Nurse Practitioner, assigned a new Director of Nursing (DON), recruiting and hiring staff nurses; and implementing training in health supports for nurses and non-licensed staff. See response to W104.</p>	12-14-09 on going

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 104	<p>Continued From page 2</p> <p>On November 16, 2009, between the hours of 5:00 p.m. and 9:30 p.m., a Licensed Practical Nurse (LPN) administered the evening medications to all eight clients in the facility. A different nurse was observed administering the medications on the evening of November 17, 2009. During the evening of November 18, 2009, a third nurse was observed administering medication to the clients.</p> <p>Interview with the Supervisory Registered Nurse on November 19, 2009 at approximately 5:00 p.m. revealed all three nurses were contracted for services through a staffing agency. Further interview and record review on the same day at approximately 5:05 p.m., revealed the facility did not have the following information available on file for review as required by District of Columbia Municipal Regulations (DCMR), Chapter 3500:</p> <ul style="list-style-type: none"> a. Copy of a service contract with the staffing agency [22 DCMR 3508.6] b. Health records of the contracted nurses [22 DCMR 3509.6] c. Competencies of the nurse to enable them to care for clients with disabilities; and [22 DCMR 3510.1] d. Verification of professional credentials (licensure) of each nurse who had provided care in the facility. [(22 DCMR 3520.2(e)] <p>There was no evidence that the facility had secured and maintained the necessary administrative documentation, prior to allowing contract nurses to provide care to the clients residing in the facility.</p>	W:104	<p>W104 This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. See response to W114 2. See response to W120 3. See response to W192 	<p>12.30.09 0790114</p>
-------	---	-------	---	-----------------------------

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 104	Continued From page 3 5. [Cross-refer to W369] The Governing body failed to develop a policy/procedure for replenishing medications as evidenced below: During the medication pass observation on November 16, 2009 at 7:00 p.m., Client #1's Metamucil and Client #2's Zocor were not available in the facility for administration. Review of the facility's Health Care Protocol Manual on November 19, 2009 at approximately 1:30 p.m. failed to evidence a policy/protocol for replenishing medications.	W 104	W104 4. The Governing Body terminated the use of contracted agency nurses. The Governing Body secured administrative documentation prior to allowing contract nurses to provide care to the clients. A contract agreement was signed and credentials to include health certificates and verification of license was obtained. The Human Resources Director faxed the necessary information to the group home site during the survey period. HR will review policies/protocols and make modifications as needed to ensure that all contracted nurses submit required documentation and complete a thorough orientation prior to rendering services. The	12-23-09 origom6	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly; date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that persons making entries into the medical record dated their entries for four of four clients included in the sample. (Clients #1, #2, #3, and #4) The finding includes: During the record verification conducted from November 16, 2009 through November 19, 2009 the following deficient practices were identified: Review of Client #1's medical record, revealed the primary care physician (PCP) failed to date entries made when he reviewed consultation documents and when countersigning interim/telephone orders. The nurses also noted this deficient practice. In addition, the PCP only documented the month and year of his monthly assessments and failed to document the exact	W 114			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 114	Continued From page 4 day on which monthly assessments were conducted. Review of Client #2's medical record, revealed the PCP failed to date entries made, when he reviewed consultation documents, and when countersigning interim/telephone orders. The nurses also noted this deficient practice. In addition, the PCP only documented the month and year of his monthly assessments and failed to document the exact day on which monthly assessments were conducted. Review of Client #3's medical record revealed the PCP failed to date entries made, when he reviewed consultation documents, and when countersigning interim/telephone orders. The nurses also noted this deficient practice. In addition, the PCP only documented the month and year of his monthly assessments and failed to document the exact day on which monthly assessments were conducted. Review of Client #4's medical record revealed the PCP failed to date entries made, when he reviewed consultation documents, and when countersigning interim/telephone orders. The nurses also noted this deficient practice. In addition, the PCP only documented the month and year of his monthly assessments and failed to document the exact day on which monthly assessments were conducted.	W 114	W104, Continued... Governing Body will ensure that QA reviews and sign the documents to verify training and administrative documents are complete. W114 This Standard will be met as evidenced by: The Medical Director/DON will review and discuss with the PCP the failure to date entries. The RN and assigned nursing staff will review all physician orders, monthly notes and address concerns as they arise. The Medical Director will continue to consult with the PCP and provide needed oversight to ensure that all of the records are dated and signed the day and month the assessment or entry was made per regulation.	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120		

12-24-09
omgpm

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 120	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement an effective system for oversight of services provided by contracted agencies for two of four clients in the sample (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that the day program implemented each active treatment program in accordance with the Individual Support Plan for (ISP) for Client #3.</p> <p>On November 17, 2009 at 12:30 p.m., Client #3 was observed dozing intermittently as she sat at the table with her peers. The instructor was observed attempting to awake the client to engage her in a tabletop activity. After opening her eyes for brief periods, at 1:05 p.m., the client continued to doze in her wheelchair. Interview with the day program staff revealed that Client #3 was usually sleepy after being administered her tube feeding by the nurse at 11:00 a.m.</p> <p>The surveyor asked staff about the client's opportunities for community outings. The staff was not aware if the client had been on any recent community outings while at her day program. Subsequent review of day program records on November 17, 2009 at 1:17 p.m. revealed one community outing was documented in 2009. According to the client's day program individualized treatment plan, she had a desired outcome to increase her community inclusion. To achieve this outcome, the interdisciplinary team (IDT) recommended a day program goal to increase the client's community integration. The corresponding objective was that, "With staff</p>	W 120	<p>W120</p> <p>This Standard will be met as evidenced by:</p> <p>1. The QMRP, Home Manager and Nursing staff are currently required to visit the day program sites at least twice monthly. A check list will be developed to for the designated managers/nurses to ensure that active treatment programs and other program interventions are adequately monitored and corrective actions are taken to address the identified concerns. The QMRP will also coordinate as needed with day program staff to ensure that staff are competently trained on each individual's treatment plan and its implementation, and can accurately document progress toward goals.</p>	12-24-09
-------	---	-------	--	----------

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	<p>Continued From page 6</p> <p>assistance (client) will visit relevant places of interest in the community once a month for three consecutive months." At the time of the survey, the review of day program records revealed the client had achieved 0% success on this objective and did not visit the community. There was no evidence the objective had been implemented as recommended.</p> <p>2. The facility failed to coordinate services with the day program to ensure its staff was trained to accurately implement Client #2's mealtime protocol as evidenced below:</p> <p>On November 17, 2009 at approximately 12:25 p.m. the surveyor and the day program case manager observed a direct care staff feeding Client #2 her lunch. The client's mealtime protocol, dated November 8, 2008 was observed on the table, near the client. As the staff presented each spoon of food to the client, she tilted her head backward and opened her mouth. She also positioned her head in this manner as she accepted water (regular consistency) from a spout cup.</p> <p>The case manager stopped Client #2's lunch at approximately 12:30 p.m. and interviewed the staff who was serving the meal and reviewed the client's mealtime protocol with him. During the interview, the case manager explained to the staff that according to Client #2's Mealtime Feeding Protocol, the following interventions were recommended:</p> <p>a. Nectar thick liquids. b. Keep her head upright at (70-80 degrees) in her wheelchair. c. Verbally cue her to close her mouth [and] take</p>	W 120	<p>W120</p> <p>2. See response to #1 above. The designee will verify that day program staff have been trained on the mealtime protocol, and will maintain a copy of the training agenda and sign-in sheet completed by the day program. The QMRP/designee will observe the mealtime protocol at the day program at least once monthly for three months to ensure that the protocol is executed properly. This process will be implemented whenever the person's mealtime protocol is revised unless otherwise documented by the IDT.</p>	12-2009 engom	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 120	<p>Continued From page 7 the food from the spoon.</p> <p>After verifying the information in the Mealtime Feeding Protocol, the day program case manager redirected the staff who was feeding Client #2, and advised him to ensure that each of the above interventions should be implemented as prescribed.</p> <p>There was no evidence at the time of survey to substantiate that the day program had ensured each staff was provided effective training and adequate oversight for implementation Client #2's mealtime protocol.</p> <p>3. The facility failed to ensure that nurses contracted by an outside agency were trained prior to providing care and services to the clients as evidenced below:</p> <p>On November 16, 2009, at 9:10 a.m. the Registered Nurse (RN) informed the surveyor of an incident that occurred on November 15, 2009. According to the RN, an agency nurse (LPN #1) informed her that medications for Client #4 was not administered at noon as prescribed due to the clients not being in the facility. A corresponding incident report reflected that the clients were not back from an outing at the time of the med pass. However, interview with direct care staff #1 on the same day at 10:28 a.m. revealed the clients did not leave the facility until 3:00 p.m. and returned between 4:30 p.m. and 5:00 p.m. Review of the Medication Administration Record (MAR) for Client #4 reflected the client was to receive Depakote 125 mg and Dilantin 100 mg at 12:00 noon. The MAR further revealed that the nurse had circled the date and documented on the back of the MAR that the client was not back from a</p>	W 120	W120	<p>3. See response to W104.4. The DON will review and update current training manuals for Agency Staff. A policy will be developed to ensure agency staff are trained and demonstrate the competencies prior to providing care and services to the people served. The governing body is no longer using agency services. This incident was reported to the agency along with a follow-up written compliant.</p> <p>12/24/09 09G121</p>	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 120	<p>Continued From page 8</p> <p>community outing. Review of the Medication Variance Report dated November 15, 2009, revealed that the physician was informed of the incident, and instructed the RN to administer the 6:00 p.m. dose as prescribed.</p> <p>4. The facility failed to ensure the nutritionist provided standards for the thickening of liquids with applesauce for Client #2.</p> <p>On November 16, 2009, at approximately 2:00 p.m. the staff served Client #2 milk that appeared to have been slightly thickened. Further observation of the liquid revealed it was not of a uniform consistency, and still appeared thin, even though some applesauce was visible at the bottom of the cup.</p> <p>According to the staff, applesauce was used to thicken liquids. Staff, however, acknowledged that the liquid was not the correct consistency. When asked how much applesauce should be added to the liquid to thicken it to the required consistency, staff stated that they add applesauce until the liquid is of the correct consistency. The RN added two to three more tablespoonful of applesauce, until the milk was thickened to a nectar consistency. During interviews with the RN and the QMRP on the same day, they both acknowledged the nutritionist did not provide specific instructions on how to thicken liquids to a nectar consistency using applesauce.</p> <p>The Nutritional Assessment dated October 13, 2008 reflected that the client "likes nectars, milk, and water mixed with applesauce." Further record review revealed no instructions had been provided to the staff on how much applesauce to add to the liquids to obtain the nectar consistency.</p>	W 120	<p>W120</p> <p>4. The Nutritionist standards for thickening of liquids with applesauce to a nectar consistency. Training will be conducted for staff to ensure that it is adequately mixed and meets the needs of the person/s served.</p> <p>The QMRP/Home Manager and nursing staff will continue to conduct meal observations, check consistency of foods and liquids and direct staff as needed as well as to provide immediate follow-up, i.e. training when problems arise.</p>	12.29.09 09G121
-------	---	-------	---	--------------------

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED: 11/19/2009
--	--	--	---

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

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

W 120	Continued From page 9	W 120		
W 137	<p>There was no evidence that the Nutritionist provided instructions to staff to ensure the client received fluids at a nectar consistency.</p> <p>483.120(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure one of four clients in the sample was afforded the opportunity to dress for varied occasions. (Client #3)</p> <p>The finding includes:</p> <p>On November 18, 2009 at 5:30 p.m., observation of clothing in Client #3's closet revealed there were primarily sweat suits and athletic-type sportswear available for her to wear.</p> <p>Interview with the staff at that time revealed Client #3 did not own any dress clothing. Further interview with staff revealed the clients take part in different types of outings, during some of which athletic type clothing/sportswear may not be appropriate attire. According to the facility's staff, a request for funds was submitted on October 22, 2009 for the amount of \$370.76 to purchase winter clothes.</p> <p>Record review on November 18, 2009, however, revealed no evidence the funds had been released or approved to complete Client #3's</p>	W 137	<p>W137 This Standard will be met as evidenced by:</p> <p>Additional clothing items have been purchased for client #3. The DRS will conduct additional training for both the QMRP/Home Manager on policy and requirements of maintaining adequate clothing supplies which reflect personal choice, maintained in good repair and accounts for a variety of occasions and seasons. QMRP/Home Manager are also expected to follow-up on requests for funds to ensure timely disbursement.</p>	12/24/09 07/20/10

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2009
--	--	--	--

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

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

W 137	Continued From page 10 winter shopping.	W 137		
W 159	<p>483 430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for six of the eight clients in the sample. (Clients #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QMRP failed to coordinate and integrate services with Client #3's day program to ensure her objective to increase her community integration was implemented as recommended in her individual support plan. [See W120 and W249] 2. The facility's QMRP failed to ensure the coordination of outside services for the accurate implementation of Client #2's mealtime protocol. [See W120.2] 3. The facility's QMRP failed to ensure each Client #3 was provided with a variety of clothing. [See W137] 4. The facility's QMRP failed to ensure all staff were effectively trained to implement mealtime feeding protocols. [See W192] 5. The facility's QMRP failed to ensure the 	W 159	<p>W159 This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. See response to W120 2. See response to W120.2 3. See response to W137 4. See response to W192 	12/24/09

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 11</p> <p>coordination of services to verify the texture of fluids required by Client #2. [See W474]</p> <p>6. The facility's QMRP failed to coordinate with nursing services to ensure Client #2 received five to six small feedings as recommended in Modified Barium Swallow Study as evidenced below:</p> <p>On November 16, 2009 at 6:25 PM staff was observed feeding Client #2 a pureed meal and water for dinner. Immediately after completing her dinner at 6:45 PM, staff gave the client an eight ounce serving of a creamy white beverage to drink.</p> <p>Interview with the staff revealed that the drink was Resource 2.0, a high calorie nutritional supplement. Further interview with staff revealed the client received Resource 2.0 twice daily (breakfast and dinner).</p> <p>Record review on November 17, 2009 revealed Client #2's Modified Barium Swallow Study (MBS) dated September 18, 2007 recommended the following:</p> <p>"Consider for five to six smaller meals a day, given the time it takes for her to complete a single swallow. (Swallowing fatigue can be a real factor for her and result in aspiration). Five or six smaller meals a day should be more optimal for this patient."</p> <p>The review of the physician's orders dated August 21, 2009, revealed the client was to receive Resource 2.0 twice daily with medication pass. The Annual Nutritional Assessment dated October 31, 2009, indicated the Resource 2.0</p>	W 159	<p>5. See response to W476. The Medical Director and PCP will review the recommendation for Resource 2.0 at med pass to determine if it can be given by trained staff as a small feeding as soon as the med pass is completed by the nurse for both morning and evening med pass. The QMRP/Designee will consult with the Nutritionist to develop a viable plan for five or six smaller meals as recommended on the Barium Swallow Study report. The Nutritionist will train staff on the new meal plan.</p>	12/21/09	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 12</p> <p>was being given to the client twice daily with medication pass (as a high calorie nutritional supplement to promote weight gain)</p> <p>Observation of the evening medication pass on November 16, 2009 and the morning medication pass on November 17, 2009 revealed that the Resource 2.0 was not given as prescribed. Interview with the nurse revealed that it was given with the meals. The review of the November 2009 MAH, however, revealed Resource 2.0 at 8:00 a.m. and 8:00 p.m. was to be given by the nurse with the medication as a small feeding between the meals. There was no evidence that Client #2 received five to six smaller meals a day as recommended in the MBS study.</p> <p>7. The QMRP failed to ensure that Client #2's interdisciplinary team reviewed the Modified Barium Swallow Study (MBS) recommendations to determine if a follow up study was warranted, prior to making changes in the mealtime protocol, as evidenced below:</p> <p>a. On November 16, 2009 at approximately 2:00 p.m. the staff was observed giving Client #2 milk that appeared to have been slightly thickened. Further observation of the liquid revealed it was not of a uniform consistency, and still appeared thin even though some applesauce was visible at the bottom of the cup. On November 16, 2009, at approximately 6:25 p.m., Client #2 was observed being given water in a regular consistency while being fed her dinner meal. The nurse was observed giving the client regular consistency water with her medications on November 16, 2009 at approximately 8:30 p.m.</p> <p>b. On November 17, 2009 at 12:25 p.m., day</p>	W 159	<p>6. The QMRP will call an IDT meeting to review the Barium Swallow Study and resolve the inconsistencies in the recommended thickening recommendations for liquids. The IDT will approve the final recommendation, the mealtime protocol will be corrected, and staff will be trained to properly implement and document the protocol.</p> <p>7. Reference response to #6.</p>	12/24/09	

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

 PRINTED: 12/03/2009
 FORM APPROVED
 OMB NO. 0988-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	<p>Continued From page 13</p> <p>program staff was observed giving Client #2 regular consistency water to drink.</p> <p>Interview with the facility's Supervisory Registered Nurse (R.N.) and the qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 2:48 p.m. revealed the client should be provided liquids in the consistency specified in the mealtime protocol.</p> <p>c. On November 17, 2009 at 3:00 p.m., the review of Client #2's Mealtime Protocol dated November 8, 2009 revealed it recommended that the consistency of all liquids be "nectar thick." According to the Annual Nutritional Assessment dated October 31, 2009, the client should continue to receive all "nectar thick" liquids. The Annual Speech Language Evaluation dated November 11, 2009, which was completed by the Speech and Language Pathologist (SLP) however, stated that she "receives all liquids thickened to a honey consistency." It should be noted, Client #2's current physician's orders, dated September 1, 2009 prescribed "Thick Liquids."</p> <p>Client #2's Modified Barium Swallow Study (MBS) dated September 18, 2007, was reviewed to determine the recommended food textures and consistency of liquids. The MBS Study revealed that the client was referred to assess the etiology of coughing and to determine current safety of swallowing. The assessment revealed that, "Of significant note was the cervical spine anomaly, as the esophageal pathway for transfer of the bolus was via an S shape instead of straight up and down." Continued review of the MBS Study revealed the following recommendations:</p>	W 159			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	<p>Continued From page 14</p> <p>(1) Pureed foods and all kind of liquids continue to be appropriate.</p> <p>(2) She should alternate food and liquid during the meal with liquid helping to move the food through the swallowing system.</p> <p>At the time of the survey, there was no evidence the QMRP had addressed the different fluid consistencies recommended by the IDT.</p> <p>8. The QMRP failed to ensure that Client #2's head positioning during intake of food and fluids was as directed in the Modified Barium Swallow Study as evidenced below:</p> <p>Client #2's Modified Barium Swallow Study (MBS) dated September 18, 2007, was reviewed to determine the recommended body positioning during food and fluid intake. The study revealed that "Of significant note was the cervical spine anomaly, as the esophageal path way for transfer of the bolus as via an S shape instead of straight up and down." Continued review of the MBS Study revealed the following recommendations:</p> <p>a. She needs to be repositioned to optimize her PO intake.</p> <p>b. Reclining to 70-80 degrees is probably best for her, as it allows gravity to move food more successfully from the front to the back of her mouth.</p> <p>c. Keep as upright as possible after mealtime has been completed, to allow for the peristalsis through the esophagus to be completed.</p> <p>According to the Mealtime Protocol dated November 8, 2009, developed by the nutritionist, staff should "Keep her head in an upright/neutral position throughout the meal." Interview with the</p>	W 159	<p>8. See responses to #s 6 and 7 above.</p> <p>9. The QMRP/RN/designee will ensure the day program receives physician orders and health protocols as soon as they are approved by the IDT. The QMRP/RN/designee will ensure that day program staff are trained to implement and document care as outlined. Also, see response to W120.1</p>	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 159	Continued From page 15 Supervisory R.N. and the QMRP on November 17, 2009 revealed that staff should follow the Mealtime Protocol. 9. The facility's QMRP failed to integrate services to ensure that Client #3's day program was informed of a prescribed change in diet. Interview with the day program nurse revealed that Client #3 was administered Arginaid (nutritional supplement) via G-tube at 11:00 a.m. Review of dietary order available at the day program revealed the client was prescribed the Arginaid. Interview with the group home revealed Client #3's Arginaid had been discontinued, and Prostat 101 had been prescribed instead. Further interview with the RN revealed she instructed one of the house LPN's to take the new diet order to the day program, however there was no evidence that her instructions had been followed.	W 159			
W 192	483.130(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 observation, interview and record review, the facility failed to ensure employees were effectively trained to provide for each client's health and safety, for four of four clients in the sample. (Clients #1, #2, #3 and #4) The findings include: 1. The facility failed to ensure the nursing staff were effectively trained to procure prescribed	W 192	W192 This Standard will be met as evidenced by: 1. Reference response to W369.1.2. and W104.4 and .5. 2. See response to #1 above. All nursing staff will receive further training on use of proper adaptive equipment when administering medications in accordance to the person's mealtime protocol. The RN will conduct random medication administration observations to further ensure compliance with this standard. RN will take immediate corrective actions if problems are noted. 3. See responses to #1 above, and to W104.4 and W159.6.	12-24-09	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 192	<p>Continued From page 16</p> <p>medications for Clients #1 and #2. [See also W3f:9.1,2]</p> <p>2. The facility failed to ensure the nursing staff was trained to utilize the proper adaptive equipment when administering medications in accordance with clients' mealtime protocols for five of six clients in the facility that received medications by mouth as evidenced below:</p> <p>During the medication administration observations conducted on November 16, 2009 and November 17, 2009 revealed the following deficient practices:</p> <p>a. During the evening medication pass observations conducted on November 16, 2009 at 5:20 p.m., the nurse administered Client #6 medication, that had been crushed and placed in applesauce. The nurse then gave the client water from the 30 cc medication cup.</p> <p>Review of Client #6's mealtime protocol dated August 31, 2009 revealed that the client used a spout cup for drinking. The nurse failed to use a spout cup when offering the client water during the medication pass. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice.</p> <p>b. During the evening medication pass observations conducted on November 16, 2009, at 5:50 p.m., the nurse administered medication to Client #1 that had been crushed and placed in applesauce. The nurse gave the client water from the 30 cc medication cup. Review of Client #1's mealtime protocol dated July 21, 2009 revealed that the client used a spout cup or squirt</p>	W 192	<p>4. See responses to #s 1 and 2 above; W104.4; W120.1, .2 and .4; W159.6-9</p>	<p>10/24/09</p>
-------	--	-------	--	-----------------

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	<p>Continued From page 17</p> <p>bottle for drinking. The protocol further reflected to offer beverages from a spoon when she does not accept them from the cup or squirt bottle. The nurse failed to use a spout cup, squirt bottle or the spoon when offering the client water during the medication pass. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice.</p> <p>c. During the morning medication pass observation conducted on November 17, 2009, at 7:11 a.m., the nurse was observed offering Client #2 water from the 30 cc medication cup. Review of the mealtime protocol dated November 8, 2009, revealed the client's liquids should be nectar thick and offered from a spout cup. The nurse failed to adhere to the mealtime protocol.</p> <p>d. During the morning medication pass observation conducted on November 17, 2009 at 8:03 a.m., the nurse crushed Client #4's medication and placed it in applesauce before giving it to her. The nurse then attempted to give the client water from the 30 cc medication cup.</p> <p>Review of Client #4's mealtime protocol dated October 18, 2009 revealed that the client should be provided a spout cup for drinking liquids. The protocol further reflects that the client's fluids should be served at a nectar consistency. The nurse failed to adhere to Client #4's mealtime protocol.</p> <p>e. During the Morning medication pass observations conducted on November 17, 2009 at 8:20 a.m., the nurse administered Client #7's medication crushed and in applesauce. The nurse gave the client water from the 30 cc</p>	W 192		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 192	<p>Continued From page 18</p> <p>medication cup. Review of Client #7's mealtime protocol dated January 16, 2009 revealed that the client used a spout cup for drinking. The nurse failed to utilize a spout cup, when offering the client water during the medication pass.</p> <p>Interview with the RN on November 17, 2009 at 3:30 p.m. revealed the agency nurses who were responsible for the med pass had not received training to ensure the needs of each client.</p> <p>3. The facility failed to ensure the agency nursing staff were trained to administer supplements as ordered for two of four clients who receive supplements as evidenced below:</p> <p>a. During the medication pass observations on the evening of November 16, 2009 and the morning of November 17, 2009, Client #2 received her medications. During the medication pass observation verification conducted on November 18, 2009 at 3:00 p.m. revealed that Client #2 was prescribed Resources 2.0 twice a day with medications. Review of the Medication Administrative Record (MAR) revealed that the supplement should have been given at 8:00 a.m. with the medication pass. The nurse failed to give the supplement as ordered.</p> <p>b. On November 17, 2009, at 8:36 a.m., Client #1 was administered her medications. Record review on November 18, 2009 at 3:00 p.m., revealed that Resource 2.0 once a day was prescribed to be given with a.m. medications. There was no evidence that the Resource was given as ordered.</p> <p>c. During the medication pass observation on November 16, 2009, at 6:45 p.m., Client #3</p>	W 192			

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

 PRINTED: 12/03/2009
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 192	<p>Continued From page 19</p> <p>received Reglan 10 mg via her Gastrostomy tube. The container indicated that the medication should be given 30 minutes prior to meals. The nurse proceeded to give Client #3 her Peptamen 250 cc bolus. The nurse informed the surveyor that the Peptamen was the Client's meal. The nurse failed to give the meal 30 minutes after the Reglan as per order.</p> <p>Further verification of the medication pass on November 18, 2009, at 3:40 p.m. revealed that Client #3 was prescribed Prostat 30 cc's which was to be given to the client at 5:00 p.m. However, the nurse was not observed administering the supplement to the client during observation from 5:00 p.m. through 9:05 p.m. as ordered.</p> <p>4. The facility failed to ensure that each employee working with Client #2 was effectively trained to implement her mealtime protocol as evidenced below:</p> <p>a. On November 16, 2009 at approximately 6:25 p.m., the surveyor observed a direct care staff feeding Client #2 her dinner. The client's mealtime protocol, dated November 8, 2009 was observed on the table, near the client. As staff presented food in the spoon to the client, she tilted her head backward and opened her mouth. She also positioned her head in this manner as she accepted regular consistency water from a sputum cup.</p> <p>Interview with the QMRP verified that Client #2's mealtime protocol identified interventions to ensure she consumed her food safely. Review of the client's mealtime feeding protocol, dated November 8, 2009 revealed the following</p>	W 192			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 249	<p>483 440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of four clients in the sample. (Clients #3)</p> <p>The finding includes:</p> <p>The facility failed to ensure that Client #3's individual program goal designed to increase her community integration was implemented at the day program as evidenced below:</p> <p>Interview with the Qualified Mental Retardation Professional on November 18, 2009 at 10:29 a.m. revealed that Client #3's lack of outings at the day program had been a concern to the interdisciplinary team (IDT)</p> <p>Record review on November 18, 2009 at 11:09 a.m., revealed that during the Individual Support Plan (ISP) on July 23, 2008, the interdisciplinary team (IDT) recommended that Client #3 improve her community integration at the day program.</p>	W 249	<p>W192, Continued & .</p> <p>5. Reference response to W120.5</p> <p>W249</p> <p>This Standard will be met as evidenced by:</p> <p>See response to W120.2</p>	12/24/09	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0988-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 192	<p>Continued From page 20</p> <p>interventions were recommended:</p> <ol style="list-style-type: none"> (1) Nectar thick liquids. (2) Keep her head upright at (70-80 degrees) in her wheelchair. (3) Verbally cue her to close her mouth [and] take the food from the spoon. <p>There was no evidence that the facility had ensured that each staff was provided training and adequate oversight for the accurate implementation of Client #2's mealtime protocol.</p> <p>b. During the evening medication administration on November 18, 2009, at approximately 8:30 p.m. the nurse was observed feeding the medication to the client with a spoon. The nurse was not observed to give any directions to the client while administering the medication.</p> <p>Interview with the facility's Supervisory Registered Nurse (RN) and the qualified mental retardation professional (QMRP) on November 17, 2009, at approximately 4:30 p.m. confirmed Client #2's mealtime feeding protocol dated November 8, 2009 recommended the following interventions: "Verbally cue her to close her mouth [after] take the food from the spoon".</p> <p>After verifying the content of the mealtime feeding protocol, the Supervisory RN and the QMRP acknowledged that the nursing staff had failed to implement the feeding protocol during medication administration.</p> <p>5. The facility failed to ensure the nutritionist provided standards and training for the thickening of liquids with applesauce for Client #2. [See W12.5]</p>	W 192		
-------	---	-------	--	--

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 22 a. According to the day program First Quarterly Report (November 2008 - January 2009), the strategy to be implemented by staff was to inform Client #3 about different choices of community outings and assist her to visit places of interest once a month for 3 consecutive months. The report further documented that during the quarter, the client had achieved 0% in the objective. The action plan, however, was that the criteria should be maintained and the objective continued. b. Review of the second quarterly review (February 2009 - April 2009) from Client #3's day program indicated she had one community outing. c. The review of third quarterly report from the Client #3's day program report dated July 2009 did not achieve the community outing objective because her arrival time conflicted with the times of the scheduled community outings. At the time of the survey, there was no evidence community outings were occurring at the day program as recommended. [See also W120.1]	W 249		
W 318	483 460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews, and record verification, the facility failed to ensure preventive health services were coordinated [Refer to W322]; the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs [Refer	W 318	W318 This Condition will be met as evidenced by: The Governing Body will review and revise (if needed) its policy for coordination of health services and health monitoring. DON will review nursing systems to ensure that nursing staff have appropriate tools and training supports to identify needs and deliver care that meets required standards. DON/RN will observe and review medication administration at least 2x monthly for the next three months to ensure that drugs are properly administered. DON/designee will provide training to staff on approved mealtime protocols;	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 318	Continued From page 23 to W331]; the facility failed to ensure drugs were administered in compliance with physician's orders [Refer to W368]; the facility failed to ensure their system for drug administration assured that all drugs are administered without error [Refer to W369]; and the facility failed to ensure staff was effectively trained to implement the clients feeding protocols [Refer to W192]	W 318	W318 Also, cross reference responses to W322, W331, W368, W369, and W192.		
W 322	The results of these systemic practices results in the demonstrated failure of the facility to provide health care services. 483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure general and preventative care services, for four of the four clients in the sample. (Client # 1, #2, #3 and #4) The finding includes: 1. The facility failed to ensure laboratory studies were completed for Client #1 as ordered by the primary care physician (PCP) as evidenced below: Review of Client #1's physician's orders on November 18, 2009, revealed the PCP ordered Hemoglobin A1C's to be obtained every six months. Review of the laboratory documents failed to evidence the studies had been obtained as ordered. Interview with the Supervisory RN on November 19, 2009, at 1:07 p.m., verified the	W 322	W322		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	<p>Continued From page 24</p> <p>studies had not been obtained as ordered.</p> <p>2. The facility failed to ensure medical evaluations by consultants for Client #3 were completed as recommended by the PCP as evidenced below:</p> <p>On November 18, 2009 at 4:10 p.m., the review of Client #3's annual medical assessment dated November 11, 2008 revealed that the PCP recommended Ophthalmology annually. Further record review revealed the client was scheduled for an annual Ophthalmology evaluation on June 16, 2008. According to the consultation report, the client refused to open her eyes and the assessment could not be completed. The consultant recommended the client be administered more sedation in order to complete the evaluation (within 4 - 8 months). Additional record review revealed the client had a corneal ulcer that was treated and resolved as of August 12, 2008. There was no evidence, however, that the client returned to Ophthalmology for the evaluation of her visual field, as recommended by the specialist.</p> <p>3. The facility failed to ensure that Client #2's wrist splints were worn daily as recommended to prevent worsening of wrist contractures.</p> <p>The review of Client #2's Annual Physical Therapy Assessment dated November 7, 2008 revealed a recommendation to "Continue with wrist splints" daily. Subsequent review of the medication administration record (MAR) on November 19, 2009 revealed that the client had worn bilateral wrist splints for 8 hours (4:00 p.m. - 12:00 a.m.) daily through the month of August 2009. Interview with the QMRP on November 18, 2009 revealed that the client's splints</p>	W 322	<p>W322</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> The RN will develop a laboratory schedule to be maintained by the LPN staff assigned to the home. The designated day LPN will be responsible for coordinating the laboratory schedules. The RN will conduct weekly monitoring to ensure ongoing compliance with recommended laboratory studies. 	12/24/09

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4964 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 322	<p>Continued From page 25</p> <p>were discarded because they were in poor condition. The QMRP reported that the client had been reassessed by the orthopedist and the physical therapist to determine the type of new wrist splints that recommended for the client.</p> <p>Record review revealed that the aforementioned assessments had been completed in October 2009 and November 2009 respectively. At the time of the survey, there was no evidence that the client had worn the wrist splints since August 2009. [See W436]</p> <p>4. The facility failed to ensure the nursing staff performed monthly breast examinations as ordered for four of four clients in the sample. (Clients #1, #2, #3, and #4)</p> <p>a. Review of the physician's orders on November 18, 2009, between 4:10 p.m. and 4:27 p.m., revealed the PCP ordered that Clients #1, #2, and #3 receive monthly breast examinations. Review of the medical records, however failed to evidence that an examination had been conducted in October 2009 for Clients #1, #2, and #3. Interview with the facility's nurse on November 19, 2009 at approximately 11:30 a.m. acknowledged that the nurse should have conducted the examinations monthly.</p> <p>b. Review of Client #4's record medical record on November 18, 2009 at 4:27 p.m., the PCP ordered the client to receive monthly breast examinations. Review of Client #4's record medical record failed to evidence that examinations were conducted in September 2009 and October 2009. Interview with the facility's nurse on November 19, 2009 at approximately 11:30 a.m. acknowledged that the nurse should</p>	W 322	<p>W322</p> <p>2. The RN in coordination with the nurse will review all PCP recommendations to ensure timely evaluation as directed by the PCP. The nursing staff are expected to document actions taken to secure appointments and results of the scheduled visits. RN will review and provide additional direction as needed.</p>	12/24/09	

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 28</p> <p>nurse failed to adhere to the mealtime protocol. According to the Annual speech and language dated November 2009, revealed a Modified Barium Swallow Study (MBS) was conducted for the client on September 18, 2007. Further review of the speech and language assessment revealed that the client demonstrated an overall functional oral and pharyngeal swallow was slow, oral initiation of the bolus during the study. The assessment recommended the client's liquids be thickened to honey consistency.</p> <p>d. During the morning medication pass observation conducted on November 17, 2009 at 8:05 a.m., the nurse administered medication crushed and placed in applesauce to Client #4. The nurse gave the client water from the 30 cc medication cup. Review of Client #4's Mealtime Protocol dated October 18, 2009 revealed that the client used a spout cup for drinking. The protocol further reflects that the client's fluids should be served at a nectar consistency. review of the speech and language assessment revealed that the client demonstrated. The review of the client's annual speech and language evaluation dated October 18, 2009 revealed the client exhibits delayed oral onset of swallow and that guidelines in the mealtime protocol guidelines are recommended to be followed. The nurse failed to adhere to Client #4's Mealtime Protocol.</p> <p>e. During the Morning medication pass observations conducted on November 17, 2009 at 8:21 a.m., the nurse administered medication crushed and placed in applesauce to Client #7. The nurse gave the client water from the 30 cc medication cup. Review of Client #7's Mealtime Protocol dated January 16, 2009 revealed that the client used a spout cup for drinking. The nurse</p>	W 331			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322 W 331	Continued From page 26 have conducted the examinations monthly. 483 460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the provision nursing services in accordance with the assessed needs of seven of the eight clients residing in the facility (Clients #1, #2, #3, #4, #6, #7, and #8). The findings include: 1. The facility failed to ensure that medications were administered in compliance with physician's orders. (See W369) 2. The facility failed to ensure their system for medication administration assured that all medications were administered without error. (See W369) 3. The facility failed to ensure the nursing staff used adaptive equipment when administering medications in accordance with clients' mealtime protocols for five of six clients in the facility that received medications as evidenced below: During the medication administration observations conducted on November 16, 2009 and November 17, 2009 revealed the following deficient practices: a. During the evening medication pass observations conducted on November 16, 2009 at 5:20 p.m., the nurse administered medication to Client #6 that had been crushed and placed in applesauce. The nurse gave the client water from the 30 cc medication cup. Review of Client #6's	W 322 W 331	W322, Continued... 3. The RN/in coordination with the QMRP and assigned nursing staff will conduct additional staff training on wrist splints. The QMRP/RN will monitor implementation weekly. Also, reference W436. 4. The monthly breast examinations are being conducted monthly as ordered. The RN will conduct weekly review of all breast examinations to ensure ongoing compliance with this standard. Disciplinary actions and/or staff training will be completed as required.	12/24/09 OSG/PM/

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 27</p> <p>Mealtime Protocol dated August 31, 2009 revealed that the client used a spout cup for drinking. The nurse failed to utilize a spout cup when offering the client water during the medication pass. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice.</p> <p>b. During the evening medication pass observations conducted on November 16, 2009 at 5:50 p.m., the nurse administered medication to Client #1 that had been crushed and placed in applesauce. The nurse gave the client water from the 30 cc medication cup. Review of Client #1's Mealtime Protocol dated July 21, 2009 revealed that the client used a spout cup or squirt bottle for drinking. The protocol further reflected to offer beverages from a spoon when she does not accept them from the cup or squirt bottle. The nurse failed to utilize a spout cup, squirt bottle or the spoon when offering the client water during the medication pass. Review of the speech and language Evaluation dated August 2008 revealed that the client has a very slow oral phase delayed initiation of swallowing. Further review of the speech and language revealed the client should receive liquids through a spout cup or squirt bottle.</p> <p>It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice.</p> <p>c. During the morning medication pass observation conducted on November 17, 2009, at 7:11 a.m. the nurse was observed offering Client #2 water from the 30 cc medication cup. Review of the Mealtime Protocol dated November 8, 2008, revealed the Client's liquids should be nectar thick, and offered from a spout cup. The</p>	W 331	<p>W331</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Reference response to W369. 2. Reference response to W369. 3. Reference response to W192. 4. Reference response to W474. 5. Reference response to W192. 	12/24/09	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0908-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 29</p> <p>failed to utilize a spout cup, when offering the client water during the medication pass. Interview with the RN on November 17, 2009 at 3:30 p.m. revealed that the agency nurses had not had any training prior to coming to the facility to care for the clients.</p> <p>4. The nursing staff failed to provide liquids in a form consistent with the client's assessed needs, during the medication pass. (See W474)</p> <p>5. The nursing staff failed to provide dietary supplements during medication administration as ordered for four of four clients who receive supplements. (Clients #1, # 2, # 3, and #6)</p> <p>a. On November 16, 2009 at approximately 6:25 p.m. Client #2 was served her dinner. After completing her dinner at approximately 15 minutes later, the client was offered a creamy white beverage from a spout cup. The surveyor asked the staff what he was giving the client to drink. The staff indicated it was Resource 2.0. Interview with the facility's Registered Nurse (RN) and the evening medication nurse on November 16, 2009 at approximately 9:15 p.m. verified the Resource was not provided during the evening medication pass.</p> <p>Further interview with the facility's RN and the qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 5:26 p.m. confirmed the following information:</p> <p>b. Client #1 was administered morning medications on November 17, 2009 at 8:36 a.m. Review of the Medication Administration Record (MAR) reflected that the nurse initialed the record as having administered the nutritional supplement, Resource 2.0, with the medications. At 8:50 a.m. the client was observed drinking a supplement with her breakfast. Interview with staff revealed that the drink was Resource 2.0. Interview with the facility's day nurse revealed at</p>	W 331		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 30</p> <p>approximately 9:40 a.m. verified the Resource was not provided to the client with meds as prescribed.</p> <p>The review of the client's physician orders for July 3, 2009 revealed to "Provide eight ounces of Resource 2.0 PO once a day with Medication Pass for nutritional supplement." There was no evidence the nurse ensure that the nutritional supplement was given at as order with the medications instead of with the client's meal.</p> <p>c. During the medication pass observation on November 16, 2009 at 6:45 p.m. Client #3 received Reglan 10 mg via her Gastrostomy tube. The container indicated that the medication should be given 30 minutes prior to meals. The nurse proceeded to give Client #3 her Peptamen 250 cc bolus. The nurse informed the surveyor that the Peptamen was the client's meal. The nurse failed to give the meal 30 minutes after the Reglan as per order.</p> <p>d. Further verification of the medication administration observation on November 16, 2009, at 3:40 p.m. revealed that Client #3 was prescribed Prostat 30 cc's to be given at 5:00 p.m. However, the nurse was not observed administering the supplement to the client during observation from 5:00 p.m. through 9:05 p.m. on November 16, 2009 as ordered. Interview with the RN on November 18, 2009 at approximately 2:00 p.m. acknowledged the deficient practice.</p> <p>e. During the medication administration observation on November 17, 2009 at 7:48 a.m., Client #6 received Calcium with vitamin D supplements, cranberry fruit, Trileptal, and Lactulose. Review of the client's interim order form dated September 20, 2009; reflected Resource 2.0 should have been administered</p>	W 331			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 31</p> <p>with medication. The nurse did not administer the supplement with the medications. Interview with the RN on November 18, 2009 at approximately 2:00 p.m. acknowledged the deficient practice.</p> <p>6. The nursing staff failed to perform monthly breast examinations as ordered by the FCP for four of four clients in the sample (See W322.4)</p> <p>7. The facility failed to ensure that Client #3's day program was informed of her prescribed change in her diet.</p> <p>Interview with the nurse at Client #3's day program on November 17, 2009 revealed due to her inability to eat by mouth, the client was prescribed a tube feeding to maintain her nutrition. Further interview the nurse revealed that the client was prescribed Arginaid Protein Powder (1 Packet) and Peptamen 1 can via G-tube.</p> <p>On November 17, 2009, review of the day program nursing office record revealed a physician's order for tube feeding: Peptamen 250 cc bolus (1 can) 3 times daily at 7:30 a.m., 12:30 p.m., and 5:30 p.m. Further record review revealed the most current physician's orders, dated September 1, 2009, failed to list the Arginaid.</p> <p>Interview with the group home nurse on November 17, 2009 at 3:30 p.m., revealed that Client #3's Arginaid had been discontinued, and that Prostat 101 had been prescribed instead.</p> <p>Further interview with the RN revealed she instructed one of the house LPNs to take the new diet order to the day program; however there was no evidence that her instructions had been followed.</p> <p>Review of the record on November 17, 2009 at 3:40 p.m. revealed a physician's order dated November 2, 2009 to discontinue Arginaid and to start Prostat 101. There was no evidence the facility's nursing services had coordinated Client</p>	W 331			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 32 #3 tube feeding order with the day program to ensure that her tube feeding was accurately administered.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that medications were administered in compliance with physician's orders for 2 of 4 clients in the sample (Clients #1 and #2) and one of the three remaining clients observed receiving medications in the facility (Client #6). The findings include: 1. The facility failed to ensure Client #1's Metamucil was administered in compliance with the physician's order. [See W369.1] 2. The facility failed to ensure Client #2's Zocor was administered in compliance with the physician's order. [See W369.2] 3. During the medication pass verification, it was discovered that the facility failed to ensure Client #5's Macrobid was administered as ordered. [See W369.3] 4. The facility failed to ensure Client #4 reflected the client was to receive Depakote 125 mg and Dilantin 100 mg were administered in compliance with the physicians orders. [See W120.3]	W 368	W369 This Standard will be met as evidenced by: Reference responses to W192, W104, W120.	12/24/09
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are	W 369		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	<p>Continued From page 33</p> <p>self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure its system for medication administration assured that all medications were administered without error for three of the eight clients residing in the facility. (Clients #1, #2 and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the medication pass observation on November 16, 2009 at 7:00 p.m., the nurse retrieved Client #1's Metamucil container, which was almost empty. Review of the container revealed the medication was prescribed for constipation. Interview with the nurse at approximately 7:03 p.m. revealed that no more Metamucil was available for Client #1. Review of the facility's Health Care Protocol Manual on November 19, 2009 at approximately 1:30 p.m. failed to evidence a policy/protocol for replenishing medications. The facility failed to ensure the availability of ordered medications. (See also W331) 2. During the Medication pass observation of November 16, 2009 at approximately 9:05 p.m. The nurse was preparing to administer medications, Lactulose and Zocor to Client #2. The nurse discovered when she entered the medication cabinet that the Zocor was not in the basket that contained her medication. Review of the facility's Health Care Protocol Manual on November 19, 2009 at approximately 1:30 p.m. failed to evidence a policy/protocol for replenishing medications. The facility failed to 	W 369		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 369	Continued From page 34 ensure the availability of prescribed medications. Interview with the RN on the same day acknowledged the medication was not available for administration. 3. During the medication pass observation conducted on November 16, 2009 between 5:20 p.m. and 9:05 p.m., Client #6 was observed receiving her evening medications that included oyster-shell calcium with vitamin D, Trileptal, lactulose and cranberry fruit. Review of the Physician's Orders dated September 2009 (valid for 120 days) to verify the medication passes on November 16, 2009, revealed Macrobid 100 mg, twice a day was to be administered. This medication was not observed being administered during the medication pass, the medication was not observed administered. Review of the Medication Administration Record (MAR), however, reflected that the nurse's initials as having administered the medication. The Registered Nurse produced the bubble pack containing the medication. The bubble pack still had the capsule of the medication that should have been administered on the November 16, 2009. The RN and the surveyor inspected both the AM and PM bubble packs and ruled out that the nurse administered the medication from the wrong bubble pack. The RN acknowledged that the medication had not been given as ordered. [See W331]	W 369			
W 436	483.70(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	W 436			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED: 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	<p>Continued From page 35</p> <p>interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and the record review, the facility failed to provide hand splints as recommended by the interdisciplinary team for five of the eight clients residing in the facility. (Clients #1, #2, #4, #6, and #7)</p> <p>The finding includes:</p> <p>On November 16, 2009, at 8:37 a.m., Client #2 was observed to have contractures of both wrist/hands.</p> <p>Interview with direct care staff on November 16, 2009 at 5:43 p.m. regarding Client #2's contractures revealed that the client had worn wrist splints in the past, however, they were currently not available. On November 17, 2009 at approximately 4:51 p.m., the qualified mental retardation professional (QMRP) confirmed that Client #2 did not have hand splints to wear. Additional interview with the QMRP on November 18, at 11:20 a.m. revealed that the client's previous wrist splints had been discarded because they were worn and in poor condition. On November 18, 2009 at approximately 4:59 p.m. the QMRP stated she had not submitted an authorization form (Form 719) for the wrist splints because she was waiting for the Physical Therapist (PT) to recommend the wrist splints. Both the QMRP and the Supervisory Registered Nurse (R.N.) acknowledged that the PT had recommended that the client wear bilateral wrist splints daily.</p>	W 436			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 36 The review of Client #2's Annual Physical Therapy Assessment dated November 7, 2008 revealed a recommendation to "continue with wrist splints" daily. The Annual PT Assessment dated November 3, 2009 included a recommendation to "Purchase new Hand splints See link for example". The review of an adaptive equipment form dated November 16, 2009 revealed "Wrist Splints - See PT recommendation for new hand splints." Subsequent review of the medication administration record (MAR) on November 19, 2009 revealed that the client had worn bilateral wrist splints for 8 hours (4:00 p.m. - 12:00 a.m.) daily through the month of August 2009. The record however failed to document a recommendation that the client's bilateral wrist splints be discontinued after August 2009. At the time of the survey, there was no evidence that the facility had timely addressed the PT's recommendations to obtain wrist splints for Client #2 to ensure they were available for her daily wear.	W 436		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to implement an effective system of monitoring and oversight to ensure	W 474		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4964 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	<p>Continued From page 37</p> <p>clients received oral fluids in a texture to meet the assessed needs for four of four sampled clients. (Clients #1, #2, #3 and #4)</p> <p>The finding includes:</p> <p>1. On November 16, 2009, at approximately 6:25 p.m., Client #2 was observed given juice in a regular consistency while being fed her dinner. The nurse was observed giving the same client regular consistency water with her medications on November 16, 2009 at approximately 8:30 p.m.</p> <p>On November 17, 2009 at 12:25 p.m., day program staff was observed giving Client #2 regular consistency water to drink. At no time was any of the staff or nurse observed to add any thickener to Client #2's fluids prior to serving it to her.</p> <p>Interview with the facility's Supervisory Registered Nurse (RN) and the qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 2:48 p.m. revealed the following information concerning the consistency of Client #2's liquids:</p> <p>a. Mealtime feeding protocol dated November 8, 2009 recommended nectar thick liquids.</p> <p>b. Annual nutritional assessment dated October 31, 2009 recommended "nectar thick" liquids.</p> <p>c. Annual speech language evaluation dated November 11, 2009 detailed her liquids are being thickened to a "honey" consistency.</p>	W 474		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	<p>Continued From page 38</p> <p>Record review on November 17, 2009 at 4:30 p.m. confirmed the information presented above was approved by the interdisciplinary team (IDT). It should be noted, however that the review of Client #2's current physician's orders, dated September 1, 2009 revealed the PCP prescribed "Thick Liquids."</p> <p>On November 17, 2009, after verifying the inconsistencies of the fluid texture recommended by the members of the IDT in their assessments, the supervisory RN indicated she would discuss the concerns with the QMRP. Additionally, the RN stated that she recommended that the IDT convene to discuss the fluid consistency discrepancies.</p> <p>The review of Client #2 Modified Barium Swallow Study dated</p> <p>At the time of the survey, however, there was no evidence that the facility had closely monitored Client #2 to ensure that her fluids were provided in accordance with her needs.</p> <p>It should be noted that prior to leaving the facility, it was determined that the staff were to adhere to the Client #2's Mealtime feeding protocol and provide her with nectar thickened liquids. [Cross Reference W120, W192]</p> <p>2. The facility failed to ensure the medication nurses provided liquids in the consistency required in their mealtime protocols for five of the eight clients residing in the facility. (Clients #1, #2, #4, #6 and #7)</p> <p>The medication administration observations conducted during the evening of November 16, 2009 and the morning of November 17, 2009</p>	W 474		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 474	<p>Continued From page 39</p> <p>revealed the following deficient practices:</p> <p>a. On November 16, 2009, at approximately 8:30 p.m., Client #2 received her medication. The nurse crushed the medication and placed it in applesauce. After administering the medication to the client with a spoon, the nurse gave the client water from the 30 cc medication cup. There was some coughing noted.</p> <p>Review of Client #2's annual speech and language evaluation dated November 8, 2009, revealed a referenced swallow study that was conducted on September 18, 2007. The study revealed that Client #2 exhibited "impaired bolus formation and transit, supraglottic penetration and aspiration during swallow with delayed reflexive throat clearing and coughing." The client's mealtime protocol dated November 8, 2009, revealed the Client's liquids should be nectar thick and offered from a spout cup. The nurse failed to provide the liquids in the specified consistency during the medication pass. Interview with the facility's Registered Nurse (RN) on November 18, 2009 at approximately 7:30 a.m. she acknowledged that the nurse should have provided nectar thick liquids.</p> <p>b. On November 17, 2009, at approximately 8:03 a.m. Client #4 received her medication. The nurse crushed the medication and placed it in applesauce. After administering the medication to the client with a spoon, the nurse gave the client water from the 30 cc medication cup. There was some coughing noted.</p> <p>Review of Client #4's Mealtime Protocol dated October 18, 2009 revealed that the client used a spout cup for drinking. The protocol further reflected that the client's fluids should be served at a nectar consistency. The nurse failed to provide the liquids in the specified consistency</p>	W 474			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 474	Continued From page 40 during the medication administration. Interview with the facility's Registered Nurse on November 18, 2009 at approximately 7:30 a.m. she acknowledged that the nurse should have provided nectar thick liquids.	W 474			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 30</p> <p>approximately 9:40 a.m. verified the Resource was not provided to the client with meds as prescribed.</p> <p>The review of the client's physician orders for July 3, 2009 revealed to "Provide eight ounces of Resource 2.0 PO once a day with Medication Pass for nutritional supplement." There was no evidence the nurse ensure that the nutritional supplement was given at as order with the medications instead of with the client's meal.</p> <p>c. During the medication pass observation on November 16, 2009 at 6:45 p.m. Client #3 received Reglan 10 mg via her Gastrostomy tube. The container indicated that the medication should be given 30 minutes prior to meals. The nurse proceeded to give Client #3 her Peptamen 250 cc bolus. The nurse informed the surveyor that the Peptamen was the client's meal. The nurse failed to give the meal 30 minutes after the Reglan as per order.</p> <p>d. Further verification of the medication administration observation on November 18, 2009, at 3:40 p.m. revealed that Client #3 was prescribed Prostat 30 cc's to be given at 5:00 p.m. However, the nurse was not observed administering the supplement to the client during observation from 5:00 p.m. through 9:05 p.m. on November 16, 2009 as ordered. Interview with the RN on November 18, 2009 at approximately 2:00 p.m. acknowledged the deficient practice.</p> <p>e. During the medication administration observation on November 17, 2009 at 7:46 a.m., Client #6 received Calcium with vitamin D supplements, cranberry fruit, Trileptal, and Lactulose. Review of the client's interim order form dated September 20, 2009; reflected Resource 2.0 should have been administered</p>	W 331		

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

PRINTED: 12/03/2009
FORM APPROVED
DMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	<p>Continued From page 31</p> <p>with medication. The nurse did not administer the supplement with the medications. Interview with the RN on November 18, 2009 at approximately 2:00 p.m. acknowledged the deficient practice.</p> <p>6. The nursing staff failed to perform monthly breast examinations as ordered by the PCP for four of four clients in the sample (See W322.4)</p> <p>7. The facility failed to ensure that Client #3's day program was informed of her prescribed change in her diet.</p> <p>Interview with the nurse at Client #3's day program on November 17, 2009 revealed due to her inability to eat by mouth, the client was prescribed a tube feeding to maintain her nutrition. Further interview the nurse revealed that the client was prescribed Arginaid Protein Powder (1 packet) and Peptamen 1 can via G-tube.</p> <p>On November 17, 2009, review of the day program nursing office record revealed a physician's order for tube feeding: Peptamen 250 cc plus (1 can) 3 times daily at 7:30 a.m., 12:30 p.m., and 5:30 p.m. Further record review revealed the most current physician's orders, dated September 1, 2009, failed to list the Arginaid.</p> <p>Interview with the group home nurse on November 17, 2009 at 3:30 p.m., revealed that Client #3's Arginaid had been discontinued, and that Prostat 101 had been prescribed instead. Further interview with the RN revealed she instructed one of the house LPNs to take the new diet order to the day program; however there was no evidence that her instructions had been followed.</p> <p>Review of the record on November 17, 2009 at 3:40 p.m. revealed a physician's order dated November 2, 2009 to discontinue Arginaid and to start Prostat 101. There was no evidence the facility's nursing services had coordinated Client</p>	W 331		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 32 #3 tube feeding order with the day program to ensure that her tube feeding was accurately administered.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that medications were administered in compliance with physician's orders for 2 of 4 clients in the sample (Clients #1 and #2) and one of the three remaining clients observed receiving medications in the facility (Client #6). The findings include: 1. The facility failed to ensure Client #1's Metamucil was administered in compliance with the physician's order. [See W369.1] 2. The facility failed to ensure Client #2's Zocor was administered in compliance with the physician's order. [See W369.2] 3. During the medication pass verification, it was discovered that the facility failed to ensure Client #6's Macrobid was administered as ordered. [See W369.3] 4. The facility failed to ensure Client #4 reflected the client was to receive Depakote 125 mg and Dilantin 100 mg were administered in compliance with the physicians orders. [See W120.3]	W 368	W369 This Standard will be met as evidenced by: Reference responses to W192, W104, W120.	12.24.09
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are	W 369		

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2009
--	--	--	--

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

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

W 369	<p>Continued From page 33</p> <p>self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure its system for medication administration assured that all medications were administered without error for three of the eight clients residing in the facility. (Clients #1, #2 and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the medication pass observation on November 16, 2009 at 7:00 p.m., the nurse retrieved Client #1's Metamucil container, which was almost empty. Review of the container revealed the medication was prescribed for constipation. Interview with the nurse at approximately 7:03 p.m. revealed that no more Metamucil was available for Client #1. Review of the facility's Health Care Protocol Manual on November 19, 2009 at approximately 1:30 p.m. failed to evidence a policy/protocol for replenishing medications. The facility failed to ensure the availability of ordered medications. (See also W331) 2. During the Medication pass observation of November 16, 2009 at approximately 9:05 p.m. The nurse was preparing to administer medications, Lactulose and Zocor to Client #2. The nurse discovered when she entered the medication cabinet that the Zocor was not in the basket that contained her medication. Review of the facility's Health Care Protocol Manual on November 19, 2009 at approximately 1:30 p.m. failed to evidence a policy/protocol for replenishing medications. The facility failed to 	W 369		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) IC PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 369	Continued From page 34 ensure the availability of prescribed medications. Interview with the RN on the same day acknowledged the medication was not available for administration. 3. During the medication pass observation conducted on November 16, 2009 between 5:20 p.m. and 9:05 p.m., Client #6 was observed receiving her evening medications that included oyster-shell calcium with vitamin D, Trileptal, lactulose and cranberry fruit. Review of the Physician's Orders dated September 2009 (valid for 90 days) to verify the medication passes on November 18, 2009, revealed Macrobid 100 mg, twice a day was to be administered. This medication was not observed being administered during the medication pass, the medication was not observed administered. Review of the Medication Administration Record (MAR), however, reflected that the nurse's initials as having administered the medication. The Registered Nurse produced the bubble pack containing the medication. The bubble pack still had the capsule of the medication that should have been administered on the November 16, 2009. The RN and the surveyor inspected both the AM and PM bubble packs and ruled out that the nurse administered the medication from the wrong bubble pack. The RN acknowledged that the medication had not been given as ordered. [See W331]	W 369			
W 436	483.70(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	W 436			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 436	<p>Continued From page 35</p> <p>interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and the record review, the facility failed to provide hand splints as recommended by the interdisciplinary team for five of the eight clients residing in the facility. (Clients #1, #2, #4, #6, and #7)</p> <p>The finding includes:</p> <p>On November 16, 2009, at 8:37 a.m., Client #2 was observed to have contractures of both wrists/hands.</p> <p>Interview with direct care staff on November 16, 2009 at 5:43 p.m. regarding Client #2's contractures revealed that the client had worn wrist splints in the past, however, they were currently not available. On November 17, 2009 at approximately 4:51 p.m., the qualified mental retardation professional (QMRP) confirmed that Client #2 did not have hand splints to wear. Additional interview with the QMRP on November 18, at 11:20 a.m. revealed that the client's previous wrist splints had been discarded because they were worn and in poor condition. On November 18, 2009 at approximately 4:59 p.m., the QMRP stated she had not submitted an authorization form (Form 719) for the wrist splints because she was waiting for the Physical Therapist (PT) to recommend the wrist splints. Both the QMRP and the Supervisory Registered Nurse (R.N.) acknowledged that the PT had recommended that the client wear bilateral wrist splints daily.</p>	W 436		
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4964 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 436	Continued From page 36 The review of Client #2's Annual Physical Therapy Assessment dated November 7, 2008 revealed a recommendation to "continue with wrist splints" daily. The Annual PT Assessment dated November 3, 2009 included a recommendation to "Purchase new Hand splints See link for example". The review of an adaptive equipment form dated November 16, 2009 revealed "Wrist Splints - See PT recommendation for new hand splints." Subsequent review of the medication administration record (MAR) on November 19, 2009 revealed that the client had worn bilateral wrist splints for 8 hours (4:00 p.m. - 12:00 a.m.) daily through the month of August 2009. The record however failed to document a recommendation that the client's bilateral wrist splints be discontinued after August 2009. At the time of the survey, there was no evidence that the facility had timely addressed the PT's recommendations to obtain wrist splints for Client #2 to ensure they were available for her daily wear.	W 436			
W 474	483 480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to implement an effective system of monitoring and oversight to ensure	W 474			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 474	<p>Continued From page 37</p> <p>clients received oral fluids in a texture to meet the assessed needs for four of four sampled clients. (Clients #1, #2, #3 and #4)</p> <p>The finding includes:</p> <p>1. (On November 16, 2009, at approximately 6:25 p.m., Client #2 was observed given juice in a regular consistency while being fed her dinner. The nurse was observed giving the same client regular consistency water with her medications on November 16, 2009 at approximately 8:30 p.m.</p> <p>On November 17, 2009 at 12:25 p.m., day program staff was observed giving Client #2 regular consistency water to drink. At no time was any of the staff or nurse observed to add any thickener to Client #2's fluids prior to serving it to her.</p> <p>Interview with the facility's Supervisory Registered Nurse (RN) and the qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 2:48 p.m. revealed the following information concerning the consistency of Client #2's liquids:</p> <p>a. Mealtime feeding protocol dated November 8, 2009 recommended nectar thick liquids.</p> <p>b. Annual nutritional assessment dated October 31, 2009 recommended "nectar thick" liquids.</p> <p>c. Annual speech language evaluation dated November 11, 2009 detailed her liquids are being thickened to a "honey" consistency.</p>	W 474			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 474	<p>Continued From page 38</p> <p>Record review on November 17, 2009 at 4:30 p.m. confirmed the information presented above was approved by the interdisciplinary team (IDT). It should be noted, however that the review of Client #2's current physician's orders, dated September 1, 2009 revealed the PCP prescribed "Thick Liquids."</p> <p>On November 17, 2009, after verifying the inconsistencies of the fluid texture recommended by the members of the IDT in their assessments, the supervisory RN indicated she would discuss the concerns with the QMRP. Additionally, the RN stated that she recommended that the IDT convene to discuss the fluid consistency discrepancies.</p> <p>The review of Client #2 Modified Barium Swallow Study dated _____</p> <p>At the time of the survey, however, there was no evidence that the facility had closely monitored Client #2 to ensure that her fluids were provided in accordance with her needs.</p> <p>It should be noted that prior to leaving the facility, it was determined that the staff were to adhere to the Client #2's Mealtime feeding protocol and provide her with nectar thickened liquids. [Cross Reference W120, W192]</p> <p>2. The facility failed to ensure the medication nurses provided liquids in the consistency required in their mealtime protocols for five of the eight clients residing in the facility. (Clients #1, #2, #4, #6 and #7)</p> <p>The medication administration observations conducted during the evening of November 16, 2009 and the morning of November 17, 2009</p>	W 474			

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 474	<p>Continued From page 39</p> <p>revealed the following deficient practices:</p> <p>a. On November 18, 2009, at approximately 8:30 p.m., Client #2 received her medication. The nurse crushed the medication and placed it in applesauce. After administering the medication to the client with a spoon, the nurse gave the client water from the 30 cc medication cup. There was some coughing noted.</p> <p>Review of Client #2's annual speech and language evaluation dated November 8, 2009, revealed a referenced swallow study that was conducted on September 18, 2007. The study revealed that Client #2 exhibited "impaired bolus formation and transit, supraglottic penetration and aspiration during swallow with delayed reflexive throat clearing and coughing." The client's mealtime protocol dated November 8, 2009, revealed the Client's liquids should be nectar thick and offered from a spout cup. The nurse failed to provide the liquids in the specified consistency during the medication pass. Interview with the facility's Registered Nurse (RN) on November 18, 2009 at approximately 7:30 a.m. she acknowledged that the nurse should have provided nectar thick liquids.</p> <p>b. On November 17, 2009, at approximately 8:03 a.m. Client #4 received her medication. The nurse crushed the medication and placed it in applesauce. After administering the medication to the client with a spoon, the nurse gave the client water from the 30 cc medication cup. There was some coughing noted.</p> <p>Review of Client #4's Mealtime Protocol dated October 18, 2009 revealed that the client used a spout cup for drinking. The protocol further reflected that the client's fluids should be served at a nectar consistency. The nurse failed to provide the liquids in the specified consistency</p>	W 474		
-------	---	-------	--	--

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

PRINTED: 12/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

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

W 474	Continued From page 40 during the medication administration. Interview with the facility's Registered Nurse on November 18, 2009 at approximately 7:30 a.m. she acknowledged that the nurse should have provided nectar thick liquids.	W 474		
-------	--	-------	--	--

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
--------------------	--	---------------	---	--------------------

1 000	<p>INITIAL COMMENTS</p> <p>A relicensure survey was conducted at this Group Home for Mentally Retarded Persons (GHMRP) on November 16, 2009 through November 19, 2009. Due to systemic deficient practices identified during the 2008 recertification survey, as well as during an investigation conducted on August 26, 2009, the State Agency determined that the full survey process be used. A random sampling of four clients from a residential population of eight females with varying degrees of mental retardation and disabilities was selected.</p> <p>The results of the survey were based on observations in the home and at two day programs. Administrative, nursing, and direct care staff interviews were conducted, as well as a review of clients' and administrative records, including a review of the unusual incident reports.</p>	1 000		
1 054	<p>3502.12 MEAL SERVICE / DINING AREAS</p> <p>Residents shall be provided training to develop eating skills and to use special eating equipment and utensils if such training is indicated in the Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement training recommended in the mealtime protocol for one of four residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Resident #2 was being fed her dinner by staff at approximately 6:25 p.m. on November 16, 2009.</p>	1 054	<p>1054</p> <p>3502.12 Meal Service/Dining Area</p> <p>This Statute will be met as evidenced by:</p> <p>See response to federal CONDITION W102, and federal deficiencies W120.2 and W159.8.</p>	12-24-09

Health Regulation Administration

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



(X6) DATE
12/24/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1054	Continued From page 1 She was observed to tilt her head back and open her mouth each time the staff presented her with food from the teaspoon and or water from the spout cup. The review of Client #2's mealtime protocol dated November 8, 2009 revealed Mealtime Feeding Protocol dsted 11/08/2008 recommended the following interventions be used when the client was receiving food or drink: 1. Keep her head upright at 70 to 80 degrees in her wheelchair. 2. Verbally cue her to close her mouth [and] take the food from the spoon. Interview with the GHMRP's Supervisory Registered Nurse (R.N.) and the qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 4:30 p.m. confirmed that the aforementioned interventions were included in Resident #2's mealtime protocol and should be implemented at all times. Neither staff from the home nor the day program were observed to prompt Resident #2 to keep her head in a neutral position during meals or verbally cue the resident to take the food from spoon. There was no evidence the resident was provided the recommended training in accordance with her mealtime protocol designed to develop her eating skills and to improve her use special eating equipment.	1054		
1055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.	1055	1055 3502.13 Meal Service/Dining Areas 1. See response to federal CONDITION W102, and federal deficiencies WW104.4, W120.2 and W192.2. 2. See response to federal deficiencies W159.7-8 and W192.2 3. See response to federal deficiency W120.4 4. See response to #1 above 5. See response to #1 above and federal deficiencies W159.6, W331 and W368.	12/24/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1055	<p>Continued From page 2</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff received effective training on the use of adaptive equipment, supplements, and liquid textures as outlined in the mealtime protocols.</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure the nursing staff was trained to use the proper adaptive equipment when administering medications, in accordance with clients' mealtime protocols for five of six clients in the facility that received medications by mouth as evidenced below:</p> <p>During the medication administration observations conducted on November 16, 2009 and November 17, 2009 revealed the following deficient practices:</p> <p>a. During the evening medication pass observations conducted on November 16, 2009 at 5:20 p.m., the nurse administered medication that had been crushed and placed in applesauce, to Client #6. The nurse gave the client water from the 30cc medication cup. Review of Client #6's Mealtime Protocol dated August 31, 2009 revealed that the client used a spout cup for drinking. The nurse failed to use a spout cup when offering the client water during the medication pass. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice.</p> <p>b. During the evening medication pass observations conducted on November 16, 2009,</p>	1055		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1055	<p>Continued From page 3</p> <p>at 5:50 p.m., the nurse administered medication to Client #1 that was crushed and placed in applesauce. The nurse gave the client water from the 30cc medication cup. Review of Client #1's Mealtime Protocol dated July 21, 2009 revealed that the client used a spout cup or squirt bottle for drinking. The protocol further reflected to offer beverages from a spoon when she does not accept them from the cup or squirt bottle. The nurse failed to use a spout cup, squirt bottle or the spoon when offering the client water during the medication pass. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice.</p> <p>c. During the morning medication pass observation conducted on November 17, 2009, at 7:11 a.m. the nurse was observed offering Client #2 water from the 30cc medication cup. Review of the Mealtime Protocol dated November 8, 2009, revealed the client's liquids should be nectar thick, and offered from a spout cup. Review of Client #4's Mealtime Protocol dated November 8, 2009 revealed that the client used a spout cup for drinking. The nurse failed to adhere to the mealtime protocol.</p> <p>d. During the morning medication pass observation conducted on November 17, 2009 at 8:03 a.m., the nurse administered medication crushed and placed in applesauce to Client #4. The nurse attempted gave the client water from the 30cc medication cup. Review of Client #4's Mealtime Protocol dated October 18, 2009 revealed that the client used a spout cup for drinking. The protocol further reflects that the client's fluids should be served at a nectar consistency. The nurse failed to adhere to Client #4's Mealtime Protocol.</p>	1055		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 055	Continued From page 4 e. During the morning medication pass observations conducted on November 17, 2009 at 8:20 a.m., the nurse administered medication crushed and placed in applesauce to Client #7. The nurse gave the client water from the 30cc medication cup. Review of Client #7's Mealtime Protocol dated January 16, 2009 revealed that the client used a spout cup for drinking. The nurse failed to utilize a spout cup, when offering the client water during the medication pass. Interview with the RN on November 17, 2009 at 3:30 p.m. revealed that the agency nurses had not had any training prior to coming to the facility to care for the clients. 2. The GHMRP failed to ensure that each employee working with Client #2 was effectively trained to implement her mealtime protocol as evidenced below: a. On November 16, 2009 at approximately 6:25 p.m., the surveyor observed a direct care staff feeding Client #2 her dinner. The client's mealtime protocol, dated November 6, 2009 was observed on the table, near the client. As staff presented food in the spoon to the client, she tilted her head backward and opened her mouth. She also positioned her head in this manner as she accepted regular consistency water from a spout cup. Interview with the QMRP verified that Client #2's Mealtime protocol identified interventions to ensure she consumed her food safely. Review of the client's Mealtime Feeding Protocol, dated November 8, 2009 revealed the following interventions were recommended: (1) Nectar thick liquids.	I 055		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 055	<p>Continued From page 5</p> <p>(2) Keep her head upright at (70-80 degrees) in her wheelchair. (3) Verbally cue her to close her mouth [and] take the food from the spoon.</p> <p>There was no evidence that the facility had ensured that each staff was provided training and adequate oversight for the accurate implementation of Client #2's mealtime protocol.</p> <p>b. During the evening medication administration on November 16, 2009, at approximately 8:30 p.m. the nurse was observed feeding the medication to the client with a spoon. The nurse was not observed to give any directions to the client while administering the medication.</p> <p>Interview with the facility's Supervisory Registered Nurse and the qualified mental retardation professional (QMRP) on November 17, 2009, at approximately 4:30 p.m. confirmed Client #2's Mealtime Feeding Protocol dated November 8, 2009 recommended the following interventions: "Verbally cue her to close her mouth [and] take the food from the spoon."</p> <p>After verifying the content of the Mealtime Feeding Protocol, the Supervisory Registered Nurse (RN) and the QMRP acknowledged that the nursing staff had failed to implement the feeding protocol during medication administration.</p> <p>3. The facility failed to ensure the nutritionist provided standards and training for the thickening of liquids with applesauce for Client #2. [See W120.5]</p> <p>4. The GHMRP failed to ensure the medication nurses provided liquids in the consistency</p>	I 055		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 055	Continued From page 6 required in their mealtime protocols for two of four residents in the sample. (Residents #2, and #4) The medication observations conducted during the evening of November 16, 2009 and the morning of November 17, 2009 revealed the following deficient practices: a. On November 17, 2009, at approximately 7:11 a.m., Resident#2 received her medication. The nurse crushed the medication and placed in applesauce. After administering the medication to the resident with a spoon, the nurse gave the resident water from the 30 cc medication cup. There was some coughing noted. Review of Resident#2's annual speech and language evaluation dated November 8, 2009; it referenced a swallow study that was conducted in 2007. The study revealed that Resident#2 exhibited "impaired bolus formation and transit, supraglottic penetration and aspiration during swallow with delayed reflexive throat clearing and coughing." The resident's Meal time Protocol dated November 8, 2009 revealed the resident's liquids should be nectar thick and offered from a spout cup. The nurse failed to provide the liquids in the specified consistency during the medication pass. Interview with the GHMRP's Registered Nurse on November 18, 2009 at approximately 7:30 p.m. she acknowledged that the nurse should have provided nectar thick liquids. b. On November 17, 2009, at approximately 8:30 a.m., Resident#4 received her medication. The nurse crushed the medication and placed it in applesauce. After administering the medication to the resident with a spoon, the nurse gave the resident water from the 30 cc medication cup. There was some coughing noted Review of Resident#4's Mealtime Protocol dated October 18, 2009 revealed that the resident used	I 055		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) IO 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
1055	<p>Continued From page 7</p> <p>a spout cup for drinking. The protocol further reflects that the resident's fluids should be served at a nectar consistency. The nurse failed to provide the liquids in the specified consistency during the medication pass. Interview with the GHMRP's Registered Nurse on November 18, 2009 at approximately 7:30 p.m. she acknowledged that the nurse should have provided nectar thick liquids.</p> <p>5. The GHMRP failed to ensure the agency nursing staff was trained to administer supplements as ordered for two of four residents who receive supplements as evidenced below:</p> <p>a. During the medication pass observations on the evening of November 16, 2009 and the morning of November 17, 2009, Resident #2 received her medications. The medication pass observation verification conducted on November 18, 2009 at 3:00 p.m. revealed that Resident #2 was prescribed Resource 2.0 twice a day with medications. Review of the Medication Administrative Record (MAR) revealed that the supplement should have been given at 8:00 a.m. with the medication pass. The nurse failed to give the supplement as ordered.</p> <p>b. During the medication pass observations on November 17, 2009, at 8:36 a.m. Resident #1 received her medications. The medication pass observation verification conducted on November 18, 2009 at 3:00 p.m. revealed that Resident #1 was prescribed Resource 2.0 once a day with medications. Review of the MAR revealed that the supplement should have been given at 8:00 a.m. with the medication pass. The nurse failed to give the supplement as ordered.</p> <p>c. During the medication pass observation on November 16, 2009 at 6:45 p.m. Resident #3</p>	1055		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1055	Continued From page 8 received Reglan 10 mg via her Gastrostomy tube. The container indicated that the medication should be given 30 minutes prior to meals. The nurse proceeded to give Resident #3 her Peptamen 250 cc bolus. The nurse informed the surveyor that the Peptamen was the residents' meal. The nurse failed to give the meal 30 minutes after the Reglan as per order. d. Further verification of the medication pass on November 18, 2009, at 3:40 p.m. revealed that Resident #3 was prescribed Prostat 30 cc's which was to be given to the resident at 5:00 p.m. However, the nurse was not observed administering the supplement to the resident during observation from 5:00 p.m. through 9:05 p.m. as ordered.	1055		
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the physical integrity of the residents' environment as required by this section. The findings include: Observations of the on the GHMRP on November 18, 2009 at 5:32 p.m. revealed the following concerns: 1. There was unfinished and unpainted plaster on	1090	1090 This Statute will be met as evidenced by: 1. Repairs have been completed. Home Manager will conduct weekly environmental home inspections, and generate "Maintenance Request form" to the Maintenance Department as if repairs are needed. The Home Manager will maintain copies of all environmental inspections and maintenance work completed. QMRP will also conduct routine home inspections and provide direction and feedback to the Home Manager as needed to further ensure compliance. 2. Reference response to #1. 3. Reference response to #1.	12/24/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 108	Continued From page 10 Record review on November 18, 2009, however, revealed no evidence the funds had been released or approved to complete Resident #3's winter shopping.	I 108		
I 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP's Qualified Mental Retardation  Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of habilitation and planning for eight of eight residents residing in the GHMRP. (Residents #1, #2, #3, #4, #5, #6, #7 and #8) The findings include: 1. The GHMRP's QMRP failed to ensure the coordination of outside services with regards to the implementation of mealtime protocols. [See Federal Deficiency Report - W120] 2. The GHMRP's QMRP failed to ensure the coordination of outside services. [See Federal Deficiency Report - Citation W120] 3. The GHMRP's QMRP failed to ensure all residents were provided with the proper and necessary allotment of clothing. [See Federal Deficiency Report - Citation W137] 4. The GHMRP's QMRP failed to ensure all staff were effectively trained to implement mealtime feeding protocols. [See Federal Deficiency Report	I 183	1183 3508.4 Administrative Support This Statute will be met as evidenced by:  1. See response to federal deficiency report W120. 2. See response to federal deficiency report W120. 3. See response to federal deficiency report W137. 4. See response to federal deficiency report W192. 5. See response to federal deficiency report W159.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
--	--	---	--

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

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

I 183	Continued From page 11 - Citation W192] 5. The GHMRP's QMRP failed to coordinate services to maximize interdisciplinary team (IDT) collaboration on the consistency of Resident #2's fluids. [See Federal Deficiency Report - Citation W159]	I 183		
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident's Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that contracts for outside services were keep on file for the regulatory agency's review. The findings include: On November 16, 2009, at approximately 10:30 a.m., the surveyors requested records from the group home administrative office to verify that contracts were available with outside services to meet the health care needs of the residents. Interview with the Supervisory Registered Nurse on November 16, 2009 p.m. revealed several nurses providing services were contracted through a staffing agency. On November 16, 2009, between the hours of 5:00 p.m. and 9:30 p.m., a Licensed Practical Nurse (LPN) administered the evening medications to all eight residents in the GHMRP. A different nurse was observed administering the	I 188	1188 3508.6 Administrative Support This Statute will be met as evidenced by: See response to W104.4	12/24/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 188	Continued From page 12 medications on the evening of November 17, 2009. During the evening of November 18, 2009, a third nurse was observed administering medication to the residents. Interview with the Supervisory Registered Nurse on November 19, 2009 at approximately 5:00 p.m. revealed all three nurses were contracted for services through a staffing agency. At the time of the survey, however, interview and record review revealed the administrative office failed to provide evidence of a complete contractual agreement to verify that the agency was in compliance with District of Columbia Municipal Regulations (DCMR), Chapter 3500 by providing the following information: a. Copy of a service contract with the staffing agency [22 DCMR 3508.6] b. Health records of the contracted nurses [22 DCMR 3509.6] c. Competencies of the nurse to enable them to care for residents with disabilities; and [22 DCMR 3510.1] d. Verification of professional credentials (licensure) of each nurse who had provided care in the GHMRP. [(22 DCMR 3520.2(e))] [See also Federal Deficiency Report - Citation W104]	I 188		
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control.	I 202	1202 3509.2: Personnel Policies This Statute will be met as evidenced by: According to the QMRP and Home Manager assigned to the home job descriptions were not requested during the survey visit. All job descriptions were up to date at the time of the survey. The Home Manager will continue to monitor the status of all job descriptions and review with staff at the time of hire, when change of status or position occurs and annually as required.	12/29/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 202	Continued From page 13 This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure all staff were provided job descriptions as required by this section. (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17) The finding includes: Interview with the GHMRP's qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 3:15 p.m., revealed that the written job descriptions were not available for the employees working in the GHMRP. The review of all records provided to the surveyor verified that no signed job descriptions for the staff working in the group home had been provided. At the time of the survey, there was no evidence to that the seventeen employees at the GHMRP had written job descriptions to outline duties and supervisory controls, as required by this section.	I 202		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure that the supervisor reviewed job descriptions with all staff annually as required. (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #17) The finding includes:	I 203	3509.3 Personnel Policies This Statute will be met as evidenced by: Reference response to 3509.2	12/24/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 203	Continued From page 14 Interview with the GHMRP's qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 3:20 p.m., revealed that the job descriptions of employees working in the GHMRP hand not been reviewed with the employees during the last twelve months. Record review at the time of the interview reflected that there were no signed job descriptions available to verify the date(s) they were last discussed with the GHMRP staff. At the time of the survey, there was no evidence that staff job descriptions had been reviewed with employees at least annually, as required by this section.	I 203		
I 208	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each employee had a health evaluation at least annually. (Staff #4, #7, #8, and #15) The finding includes: Interview with the facility's qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 3:30 p.m. revealed that the administrative office had not provided a	I 208	3509.6: Personnel Policies This Statute will be met as evidenced by: The Human Resource Director has secured health certificates for the identified employees. Human Resource Department will continue to maintain master listing of health certifications and due dates. Human Resource Department will generate notices to employees at least 30 days prior to expiration date to allow the employee sufficient time. QA monitoring will be completed at least quarterly to ensure ongoing compliance with this standard.	12/24/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 208	Continued From page 15 current health certificate for Staff #4, #7, #8 and #15. The review of all staff records provided during the survey verified that the administrative office failed to provide health certificates (dated within the last twelve months) for the four aforementioned staff. At the time of the survey, there was no evidence the health status of each employee working in the GHMRP would allow them the perform the necessary duties, as required by this section.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview, and record verification, the GHMRP failed to ensure that staff received training on the residents' liquid textures and the use of adaptive equipment during medication administration for five of the eight residents in the survey. (Residents #1, #2, #4, #6, and #7). The findings include: 1. There was no evidence that agency nurse were provided training on the the use of adaptive equipment during medication administration. [See Federal Deficiency Report - Citation W331.3 a, b, c, d, and e].	I 229	1229 3510.5(f) Staff Training This Statute will be met as evidenced by: 1. See response to federal deficiency W331.3 and W192.2 2. See response to federal deficiency -W474.2 a and b. 3. See response to federal deficiency W120.4 and W192.5 4. See response to federal deficiency W436	12/24/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 16 2. There was no evidence that the agency nurses were provided training on the liquid consistency requirements for the residents during medication administration. [See Federal Deficiency Report - Citation W474.2 a and b]. 3. There was no evidence that direct care staff were provided with training on how to thicken liquids to a nectar consistency using applesauce. [See Federal Deficiency Report - Citation W192.5 and W120.4] 4. The group home for the GHMRP failed to ensure training was provided to each staff in the area of Assistive Technologies as identified below: (Staff #1, #6, #10 and #11) Interview with the facility 's qualified mental retardation professional (QMRP) and record review November 17, 2009 at approximately 3:40 P.M. verified only four of seventeen staff received training in the area of assistive technologies. [Cross Reference Federal Deficiency Report - Citation W436]	I 229		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that persons making entries into the medical record dated their entries for four of four residents included in the sample. (Residents #1, #2, #3, and #4) The Finding includes: During the record verification conducted from	I 291	This Statute will be met as evidenced by: See response to federal deficiency W114	<i>12/24/09</i>

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 291	Continued From page 17 November 16, 2009 through November 19, 2009 the following deficient practices were identified: a. Review of Resident #1's medical record, the primary care physician failed to date entries made when he reviewed consultation documents and when countersigning interim/telephone orders. This deficient practice was also noted by the nurses. In addition The PCP only documented the month and year of his monthly assessments and failed to document the exact day on which monthly assessments were conducted. b. Review of Resident #2's medical record, the primary care physician failed to date entries made when he reviewed consultation documents and when countersigning interim/telephone orders. This deficient practice was also noted by the nurses. In addition The PCP only document the month and year of his monthly assessments and failed to document the exact day on which monthly assessments were conducted. c. Review of Resident #3's medical record the primary care physician failed to date entries made when he reviewed consultation documents and when countersigning interim/telephone orders. This deficient practice was also noted by the nurses. In addition The PCP only document the month and year of his monthly assessments and failed to document the exact day on which monthly assessments were conducted. d. Review of Resident #4's medical record the primary care physician failed to date entries made when he reviewed consultation documents and when countersigning interim/telephone orders. This deficient practice was also noted by the nurses. In addition The PCP only document the month and year of his monthly assessments and	I 291		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 291	Continued From page 18 failed to document the exact day on which monthly assessments were conducted.	I 291		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure the provision nursing services in accordance with the assessed needs of seven of the eight residents residing in the GHMRP (Residents #1, #2, #3, #4, #6, #7, and #8). The findings include: 1. The GHMRP failed to ensure that medications were administered in compliance with physician's orders. (See W369) 2. The GHMRP failed to ensure their system for medication administration assured that all medications were administered without error. (See W369) 3. The GHMRP failed to ensure the nursing staff used adaptive equipment when administering medications in accordance with residents'	I 395	1395 3520.2(e) Profession Services: General Provisions This Statute will be met as evidenced by: 1. See federal deficiency W368 and W369 2. See response to #1 above. 3. See response to #1 above. 4. See response to federal deficiency W474. 5. See response to federal deficiencies W159.6, W192.3 and W368 6. See response to federal deficiencies W322.1-4 7. See response to federal deficiency W159.9	12/29/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4984 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 395	Continued From page 19 mealttime protocols for five of six residents in the GHMRP that received medications as evidenced below: During the medication administration observations conducted on November 16, 2009 and November 17, 2009 revealed the following deficient practices: a. During the evening medication pass observations conducted on November 16, 2009 at 5:20 p.m., the nurse administered medication to Resident #6 that had been crushed and placed in applesauce. The nurse gave the resident water from the 30 cc medication cup. Review of Resident #6's Mealttime Protocol dated August 31, 2009 revealed that the resident used a spout cup for drinking. The nurse failed to utilize a spout cup when offering the resident water during the medication pass. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice. b. During the evening medication pass observations conducted on November 16, 2009 at 5:50 p.m., the nurse administered medication to Resident #1 that had been crushed and placed in applesauce. The nurse gave the resident water from the 30 cc medication cup. Review of Resident #1's Mealttime Protocol dated July 21, 2009 revealed that the resident used a spout cup or squirt bottle for drinking. The protocol further reflected to offer beverages from a spoon when she does not accept them from the cup or squirt bottle. The nurse failed to utilize a spout cup, squirt bottle or the spoon when offering the resident water during the medication pass. Review of the speech and language Evaluation dated August 2008 revealed that the resident has a very slow oral phase delayed initiation of swallowing. Further review of the speech and	I 395		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 20 language revealed the resident should receive liquids through a spout cup or squirt bottle. It should be noted that the nurse that administered the morning medication on November 17, 2009 repeated the aforementioned deficient practice. c. During the morning medication pass observation conducted on November 17, 2009, at 7:11 a.m. the nurse was observed offering Resident #2 water from the 30 cc medication cup. Review of the Mealtime Protocol dated November 8, 2009, revealed the Resident's liquids should be nectar thick, and offered from a spout cup. The nurse failed to adhere to the mealtime protocol. According to the Annual speech and language dated November 2009, revealed a Modified Barium Swallow Study (MBS) was conducted for the resident on September 18, 2007. Further review of the speech and language assessment revealed that the resident demonstrated an overall functional oral and pharyngeal swallow was slow, oral initiation of the bolus during the study. The assessment recommended the resident's liquids be thickened to honey consistency. d. During the morning medication pass observation conducted on November 17, 2009 at 8:03 a.m., the nurse administered medication crushed and placed in applesauce to Resident #4. The nurse attempted gave the resident water from the 30 cc medication cup. Review of Resident #4's Mealtime Protocol dated October 18, 2009 revealed that the resident used a spout cup for drinking. The protocol further reflects that the resident's fluids should be served at a nectar consistency. review of the speech and language assessment revealed that the resident demonstrated. The review of the resident's	I 395		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 21 annual speech and language evaluation dated October 18, 2009 revealed the resident exhibits delayed oral onset of swallow and that guidelines in the mealtime protocol guidelines are recommended to be followed. The nurse failed to adhere to Resident #4's Mealtime Protocol. e. During the Morning medication pass observations conducted on November 17, 2009 at 8:20 a.m., the nurse administered medication crushed and placed in applesauce to Resident #7. The nurse gave the resident water from the 30 cc medication cup. Review of Resident #7's Mealtime Protocol dated January 16, 2009 revealed that the resident used a spout cup for drinking. The nurse failed to utilize a spout cup, when offering the resident water during the medication pass. Interview with the RN on November 17, 2009 at 3:30 p.m. revealed that the agency nurses had not had any training prior to coming to the GHMRP to care for the residents. 4. The nursing staff failed to provide liquids in a form consistent with the resident's assessed needs, during the medication pass. (See W474) 5. The nursing staff failed to provide dietary supplements during medication administration as ordered for four of four residents who receive supplements. (Residents #1, # 2, # 3, and #6) a. On November 16, 2009 at approximately 6:25 p.m., Resident #2 was served her dinner. After completing her dinner at approximately 15 minutes later, the resident was offered a creamy white beverage from a spout cup. The surveyor asked the staff what he was giving the resident to drink. The staff indicated it was Resource 2.0. Interview with the GHMRP's Registered Nurse (RN) and the evening medication nurse on November 16, 2009 at approximately 9:15 p.m. verified the Resource was not provided during the evening medication pass.	I 395		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 22 Further interview with the GHMRP's RN and the qualified mental retardation professional (QMRP) on November 17, 2009 at approximately 5:26 p.m. confirmed the following information: b. Resident #1 was administered morning medications on November 17, 2009 at 8:36 a.m. Review of the Medication Administration Record (MAR) reflected that the nurse initialed the record as having administered the nutritional supplement, Resource 2.0. with the medications. At 8:50 a.m. the resident was observed drinking a supplement with her breakfast. Interview with staff revealed that the drink was Resource 2.0. Interview with the GHMRP's day nurse revealed at approximately 9:40 a.m. verified the Resource was not provided to the resident with meds as prescribed. The review of the resident's physician orders for July 3, 2009 revealed to "Provide eight ounces of Resource 2.0 PO once a day with Medication Pass for nutritional supplement." There was no evidence the nurse ensure that the nutritional supplement was given at as order with the medications instead of with the resident's meal. c. During the medication pass observation on November 16, 2009 at 6:45 p.m. Resident #3 received Reglan 10 mg via her Gastrostomy tube. The container indicated that the medication should be given 30 minutes prior to meals. The nurse proceeded to give Resident #3 her Peptamen 250 cc bolus. The nurse informed the surveyor that the Peptamen was the resident's meal. The nurse failed to give the meal 30 minutes after the Reglan as per order. d. Further verification of the medication administration observation on November 18, 2009, at 3:40 p.m. revealed that Resident #3 was prescribed Prostat 30 cc's to be given at 5:00	I 395		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 23 p.m. However, the nurse was not observed administering the supplement to the resident during observation from 5:00 p.m. through 9:05 p.m. on November 16, 2009 as ordered. Interview with the RN on November 18, 2009 at approximately 2:00 p.m. acknowledged the deficient practice. e. During the medication administration observation on November 17, 2009 at 7:48 a.m., Resident #6 received Calcium with vitamin D supplements, cranberry fruit, Trileptal, and Lactulose. Review of the resident's interim order form dated September 20, 2009; reflected Resource 2.0 should have been administered with medication. The nurse did not administer the supplement with the medications. Interview with the RN on November 18, 2009 at approximately 2:00 p.m. acknowledged the deficient practice. 6. The nursing staff failed to perform monthly breast examinations as ordered by the PCP for four of four residents in the sample (See W322.4) 7. The GHMRP failed to ensure that Resident #3's day program was informed of her prescribed change in her diet. Interview with the nurse at Resident #3's day program on November 17, 2009 revealed due to her inability to eat by mouth, the resident was prescribed a tube feeding to maintain her nutrition. Further interview the nurse revealed that the resident was prescribed Arginaid Protein Powder (1 Packet) and Peptamen 1 can via G-tube. On November 17, 2009, review of the day program nursing office record revealed a physician's order for tube feeding: Peptamen 250 cc bolus (1 can) 3 times daily at 7:30 a.m., 12:30 p.m., and 5:30 p.m. Further record review revealed the most current physician's orders, dated September 1, 2009, did not list the	I 395		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 395	Continued From page 24 Arginaid. Interview with the group home nurse on November 17, 2009 at 3:30 p.m., revealed that Resident #3's Arginaid had been discontinued, and that Prostat 101 had been prescribed instead. Further interview with the RN revealed she instructed one of the house LPNs to take the new diet order to the day program; however there was no evidence that her instructions had been followed. Review of the record on November 17, 2009 at 3:40 p.m. revealed a physician's order dated November 2, 2009 to discontinue Arginaid and to start Prostat 101. There was no evidence the GHMRP's nursing services had coordinated Resident #3 tube feeding order with the day program to ensure that her tube feeding was accurately administered.	I 395		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure services were provided in accordance with the needs of four of four residents in the sample. (Residents # 1, #2, #3 and #4) The findings include: 1. The facility failed to ensure laboratory studies	I 401	1401 3520.3 Profession Services: General Provisions This Statute will be met as evidenced by: 1. See response to federal CONDITION W318 and W322. 2. See response to #1. 3. See response to #1. 4. See response to #1.	12/22/09

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1401	<p>Continued From page 25</p> <p>were completed for Resident #1 as ordered by the primary care physician (PCP) as evidenced below:</p> <p>Review of Resident #1's physician's orders on November 18, 2009, revealed the PCP ordered Hemoglobin A1C's to be obtained every six months. Review of the laboratory documents failed to evidence the studies had been obtained as ordered. Interview with the Supervisory RN on November 19, 2009, at 1:07 p.m., verified the studies had not been obtained as ordered.</p> <p>2. The facility failed to ensure medical evaluations by consultants for Resident #3 were completed as recommended by the PCP as evidenced below:</p> <p>On November 18, 2009 at 4:10 p.m., the review of Resident #3's annual medical assessment dated November 11, 2008 revealed that the PCP recommended Ophthalmology annually. Further record review revealed the resident was scheduled for an annual Ophthalmology evaluation on June 16, 2008. According to the consultation report, the resident refused to open her eyes and the assessment could not be completed. The consultant recommended the resident be administered more sedation in order to complete the evaluation (within 4 - 6 months). Additional record review revealed the resident had a corneal ulcer that was treated and resolved as of August 12, 2008. There was no evidence, however, that the resident returned to Ophthalmology for the evaluation of her visual field, as recommended by the specialist.</p> <p>3. The facility failed to ensure that Resident #2's wrist splints were worn daily as recommended to prevent worsening of wrist contractures.</p>	1401		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 26 The review of Resident #2's Annual Physical Therapy Assessment dated November 7, 2008 revealed a recommendation to "Continue with wrist splints" daily. Subsequent review of the medication administration record (MAR) on November 19, 2009 revealed that the resident had worn bilateral wrist splints for 8 hours (4:00 p.m. - 12:00 a.m.) daily through the month of August 2009. Interview with the QMRP on November 18, 2009 revealed that the resident's splints were discarded because they were in poor condition. The QMRP reported that the resident had been reassessed by the orthopedist and the physical therapist to determine the type of new wrist splints that recommended for the resident. Record review revealed that the aforementioned assessments had been completed in October 2009 and November 2009 respectively. At the time of the survey, there was no evidence that the resident had worn the wrist splints since August 2009. [See W436] 4. The facility failed to ensure the nursing staff performed monthly breast examinations as ordered for four of four residents in the sample. (Residents #1, #2, #3, and #4) a. Review of the physician's orders on November 18, 2009, between 4:10 p.m. and 4:27 p.m., revealed the PCP ordered that Residents #1, #2, and #3 receive monthly breast examinations. Review of the medical records, however failed to evidence that an examination had been conducted in October 2009 for Residents #1, #2, and #3. Interview with the facility's nurse on November 19, 2009 at approximately 11:30 a.m. acknowledged that the nurse should have conducted the examinations monthly.	I 401		

PRINTED: 12/03/2009
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 27 b. Review of Resident #4's record medical record on November 18, 2009 at 4:27 p.m., the PCP ordered the resident to receive monthly breast examinations. Review of Resident #4's record medical record failed to evidence that examinations were conducted in September 2009 and October 2009. Interview with the facility's nurse on November 19, 2009 at approximately 11:30 a.m. acknowledged that the nurse should have conducted the examinations monthly.	I 401		