

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

PRINTED: 01/29/2010  
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  R 12/29/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019
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(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
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{W 000}	<p><b>INITIAL COMMENTS</b></p> <p>A revisit was conducted on December 29, 2009, to verify the facility's compliance with condition-level deficiencies cited during the November 19, 2009 recertification survey. Two clients remained in the sample from the previous survey and two new clients were added from a residential population of six females with various disabilities. The findings of the survey were based on observations in the home and at one day program, interviews with day program staff, direct care and nursing staff in both locations, as well as a review of clinical, administrative, and habilitative records, including a review of unusual incident reports.</p> <p>The revisit resulted in a determination that the facility had regained compliance with the Conditions of Participation in Governing Body and Health Care Services.</p>	{W 000}	<p><i>Recvd 2/1/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
{W 104}	<p><b>483.410(a)(1) GOVERNING BODY</b></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 exercised general operating direction over the facility, except for in the following areas:</p> <p>The findings include:</p> <p>1. The governing body failed to ensure its professional services dated all entries documented in the medical records. [See W114]</p>	{W 104}	<p><b>W104</b></p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Reference response to W114.</li> <li>2. Reference response to W120.</li> </ol>	<p><i>1/2/10</i></p> <p><i>Chen</i></p>

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

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
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{W 104}	Continued From page 1 2. The governing body failed to ensure that day programs met the needs of each client. [See W120]	{W 104}	W120	
{W 120}	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that outside services met the needs of each client, for two of the four clients in the sample. (Clients #2 and #8)</p> <p>The findings include:</p> <p>1. According to the facility's Plan of Correction (POC), dated December 24, 2009, the qualified mental retardation professional (QMRP) would verify that day program staff had been trained on mealtime protocols and would maintain a copy of the training agenda and signature sheet completed by the day program. The QMRP would also observe meals at the day program monthly, for three months, to ensure that mealtime protocols were executed properly.</p> <p>Client #2 was observed receiving lunch at her day program on December 29, 2009, beginning at 11:56 a.m. Her meal consisted of pureed baked fish, mashed potatoes, mixed vegetables, chocolate pudding and water. At 12:00 p.m., following some spoonfuls of food, Client #2 was given a sip of water. She immediately made loud vocalizations. Staff thought the client's vocalizations reflected displeasure with the lemon flavored thickener they used. The water</p>	{W 120}	<p>This Standard will be met as evidenced by:</p> <p>1. The QMRP verified that the day program staff had been trained on mealtime protocol. The QMRP and designated nursing staff will ensure that a copy of the information is maintained at the day program and residence for review. The QMRP and LPN staff will continue to follow-up with the day program to verify implementation of the mealtime protocols.</p> <p>Client #2 was evaluated by the Speech Therapist and is no longer being recommended for thickened liquids. Applesauce continues to be provided for flavor. Her mealtime protocol has been updated to reflect the changes and staff training will be conducted reflective of the changes. QMRP and designated LPN staff will ensure that staff training is completed at the day program site.</p>	12/29/09 02:12pm

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{W 120}	<p>Continued From page 2 appeared to be of nectar consistency.</p> <p>At 12:02 p.m., staff stirred two (2) teaspoons of "thick it" into apple juice and gave it to the client. The apple juice appeared to be of thinner consistency than nectar. The client drank it, however, without incident. When asked, the staff confirmed that he had used 2 teaspoons of thickener. Moments later, the staff added an additional tablespoon of thickener to the client's apple juice which made it nectar thick. When asked about training, the staff stated that the QMRP, facility nurse, and house manager had provided training on Client #2's mealtime protocol on December 28, 2009 (the day before this survey).</p> <p>At approximately 12:23 p.m., review of Client #2's mealtime protocol, dated December 28, 2009, revealed the following order: "low fat/cholesterol, pureed with added fiber with nectar thick liquids (2 tsp of thick &amp; easy mixed in 8 oz. of liquid)." When shared with the day program staff who fed Client #2, he acknowledged that he had used the wrong "teaspoon" end of the measuring spoon that was placed inside of the "thick it" container. Later that afternoon, at approximately 3:30 p.m., review of the facility's in-service training records confirmed that day program staff were trained on Client #2's mealtime protocol on December 28, 2009. Observations at lunch the next day, however, indicated that the training had not been effective.</p>	{W 120}	<p>W120, continued...</p> <p>Routine record reviews and direct observations will be conducted by QA/designated staff and corrective actions taken to address concerns as they arise.</p>	
W 154	<p>483.42J(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p>	W 154		

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W 154	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all injuries for one of the eight clients residing in the facility. (Client #8)</p> <p>The finding includes:</p> <p>On December 29, 2009, beginning at approximately 10:26 a.m., review of incident reports and corresponding investigations revealed an investigation report dated December 9, 2009. According to the investigation, that was prepared by the facility's qualified mental retardation professional (QMRP), Client #8 sustained an injury to her face while riding in the facility's vehicle. The client's wheelchair rolled against the other side of the van... abrasion on her right cheek. The investigation report indicated that, as per the primary care physician's order, the client was evaluated at an emergency room and released the same day. Recommendations were to continue monitoring the client for any changes and "provide additional training on transfer and repositioning." At approximately 10:40 a.m., the QMRP was asked about the incident. She attributed the injury to the vehicle having turned sharply, which caused the Client #8's wheelchair to move abruptly.</p> <p>At approximately 4:55 p.m., interview with one of the two staff who were on board the vehicle at the time of the incident revealed that the client's wheelchair had moved forward and she had hit her face against a wheelchair in front of her. This accounting differed from what was presented in the investigation report.</p> <p>{W.159} 483.43(a) QUALIFIED MENTAL</p>	W 154	<p><b>W154</b></p> <p>This standard will be met as evidenced by:</p> <p>The Facility Coordinator completed training for all staff on proper tie-down procedures. The facility Coordinator and QMRP will routinely inspect for competency and provide additional training and follow-up as needed.</p> <p>The investigative report was consistent with staff interview according to QMRP who was present when the surveyor conducted the interviews.</p> <p>Vehicle safety procedure will continue to be monitored by the Fleet Inspector to ensure that all components are maintained in good working order. An Incident Management Coordinator has been hired who will directly oversee and conduct staff interviews as needed to further ensure that information is accurate. All incidents will be discussed at the safety review meetings.</p>	<p>2010</p> <p>01/29/2010</p>
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{W 159}	<p>Continued From page 4</p> <p><b>RETARDATION PROFESSIONAL</b></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 two of the four clients in the sample. (Clients #2 and #8)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Cross-refer to W120.1. The facility's QMRP failed to ensure the coordination of services to verify the texture of fluids required by Client #2.</li> <li>2. Cross-refer to W154. The facility's QMRP failed to thoroughly investigate all incidents.</li> </ol>	{W 159}	<p><b>W159</b></p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Cross reference to W120.1</li> <li>2. Cross reference response to W154.</li> </ol>	12/29/09
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{W 474}	<p><b>483.480(b)(2)(iii) MEAL SERVICES</b></p> <p>Food must be served in a form consistent with the developmental level of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one of four clients in the sample (Client #2) received fluids in the form and consistency as prescribed in her mealtime protocol.</p> <p>The finding includes:</p> <p>Cross-refer to W120. According to the facility's</p>	{W 474}	<p><b>W474</b></p> <p>This Standard will be met as evidenced by:</p> <p>Cross reference response to W120.</p>	12/29/09
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{W 474} Continued From page 5

Plan of Correction (POC), dated December 24, 2009, the qualified mental retardation professional and house manager would conduct additional staff training and meal observations at the day program to ensure ongoing compliance with this standard and provide immediate actions (i.e. retraining, disciplinary actions) when needed.

On December 29, 2009, lunch time observations at the day program revealed that staff failed to ensure that Client #2's apple juice was thickened to a nectar consistency, as prescribed in the mealtime protocol.

{W 474}

[Faint, mostly illegible text in the provider's plan of correction column]

[Faint, mostly illegible text in the completion date column]

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(1 000)	<p><b>INITIAL COMMENTS</b></p> <p>A follow up licensure survey was conducted on December 29, 2009, to verify the GHMRP's compliance with condition-level deficiencies cited during the November 19, 2009 licensure survey. Two residents remained in the sample from the previous survey and two new residents were added from a residential population of six females with various disabilities. The findings of the survey were based on observations in the home and one day program, interviews with day program staff, direct care and nursing staff, as well as a review of the clinical, administrative, and habilitative records, including a review of the unusual incident reports.</p>	(1 000)		
1.042	<p><b>3502.2(b) MEAL SERVICE / DINING AREAS</b></p> <p>Modified diets shall be as follows:</p> <p>(b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that one of four residents in the sample (Resident #2) received fluids in the form and consistency as prescribed in her mealtime protocol.</p> <p>The finding includes: According to the facility's Plan of Correction (POC), dated December 24, 2009, the qualified mental retardation professional (QMRP) would verify that day program staff had been trained on mealtime protocols and would maintain a copy of the training agenda and signature sheet completed by the day program. The QMRP</p>	1.042	<p>1.042</p> <p><b>3502.2 (b)</b></p> <p>This Statute will be met as evidenced by: Reference response to W120.</p>	<p>1/2/10</p> <p>1/2/10</p>

Health Regulation Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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1042	<p>Continued From page 1</p> <p>would also observe meals at the day program monthly, for three months, to ensure that mealtime protocols were executed properly.</p> <p>According to the facility's Plan of Correction (POC), dated December 24, 2009, the qualified mental retardation professional (QMRP) would verify that day program staff had been trained on mealtime protocols and would maintain a copy of the training agenda and signature sheet completed by the day program. The QMRP would also observe meals at the day program monthly, for three months, to ensure that mealtime protocols were executed properly.</p> <p>Resident #2 was observed receiving lunch at her day program on December 29, 2009, beginning at 11:55 a.m. Her meal consisted of pureed, baked fish, mashed potatoes, mixed vegetables, chocolate pudding and water. At 12:00 p.m., following some spoonfuls of food, Resident #2 was given a sip of water. She immediately made loud vocalizations. Staff thought the resident's vocalizations reflected displeasure with the lemon flavored thickener they used. The water appeared to be of nectar consistency.</p> <p>At 12:02 p.m., staff stirred two (2) teaspoons of "thick it" into apple juice and gave it to the resident. The apple juice appeared to be of thinner consistency than nectar. The resident drank it, however, without incident. When asked, the staff confirmed that he had used 2 teaspoons of thickener. Moments later, the staff added an additional tablespoon of thickener to the resident's apple juice which made it nectar thick. When asked about training, the staff stated that the QMRP, facility nurse, and house manager had provided training on Resident #2's mealtime protocol on December 28, 2009 (the day before</p>	1042		
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1042	<p>Continued From page 2 this survey).</p> <p>At approximately 12:23 p.m., review of Resident #2's mealtime protocol, dated December 28, 2009, revealed the following order: "low fat/cholesterol, pureed with added fiber with nectar thick liquids (2 tbsp of thick &amp; easy mixed in 8 oz. of liquid)." When shared with the day program staff who fed Resident #2, he acknowledged that he had used the wrong ("teaspoon") end of the measuring spoon that was placed inside of the "thick it" container. Later that afternoon, at approximately 3:30 p.m., review of the facility's in-service training records confirmed that day program staff were trained on Resident #2's mealtime protocol on December 28, 2009. Observations at lunch the next day, however, indicated that the training had not been effective.</p>	1042	<p>1090</p> <p>3504.1</p> <p>This Statute will be met as evidenced by:</p> <p>Unfinished and unpainted plaster on the lower sections of the wall along both hallways will be repaired and painted. The Home Manager will ensure that maintenance requests are generated whenever concerns arise. The Home Manager will complete a comprehensive environmental audit on a monthly basis and routine inspections at least weekly. All concerns will forwarded to the maintenance department. The Facility Manager will maintain verification of completed repairs.</p> <p>The screen has been replaced near the corner of the dining room. The screen has been replaced. reference response to #3.</p> <p>3. The screen has also been replaced for client #</p>	
(1090)	<p>3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the physical integrity of the residents' environment as required by this section.</p> <p>The findings include:</p> <p>Observations of the GHMRP on November 18, 2009 at 5:32 p.m. revealed the following concerns:</p>	(1090)		

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{1 080}	Continued From page 3  1. There was unfinished and unpainted plaster on the lower sections of the walls along both hallways.  2. The screen was missing from the window near the corner of the dining room.  3. A screen was missing from a window in the bedroom of Residents #2 and #7, and in the bedroom of Residents #4 and #8.	{1 090}		
{1 183}	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 observation, staff interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for two of the four residents in the sample. (Residents #2 and #8)  The findings include:  1. Cross-refer to 1042. The facility's QMRP failed to ensure the coordination of services to verify the texture of fluids required by Resident #2.  2. The facility's QMRP failed to thoroughly investigate all incidents as follows:  On December 29, 2009, beginning at approximately 10:26 a.m., review of incident reports and corresponding investigations revealed an investigation report dated December	{1 183}	3508.4  This Statute will be met as evidenced by:  1. Cross refer to 1042 and W120.  2. Cross refer to W154.	1-22-10 DMM/MS

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(1183)	<p>Continued From page 4</p> <p>9, 2009. According to the investigation, that was prepared by the facility's qualified mental retardation professional (QMRP), Resident #8 sustained an injury to her face while riding in the facility's vehicle. The resident's "wheelchair rolled against the other side of the van... abrasion on her right cheek." The investigation report indicated that, as per the primary care physician's order, the resident was evaluated at an emergency room and released the same day. Recommendations were to continue monitoring the resident for any changes and "provide additional training on transfer and repositioning." At approximately 10:40 a.m., the QMRP was asked about the incident. She attributed the injury to the vehicle having turned sharply, which caused the Resident #8's wheelchair to move abruptly.</p> <p>At approximately 4:55 p.m., interview with one of the two staff who were on board the vehicle at the time of the incident revealed that the resident's wheelchair had moved forward and she had hit her face against a wheelchair in front of her. This accounting differed from what was presented in the investigation report.</p>	(1183)		
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(1229)	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(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;</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record</p>	(1229)	<p>3510.5</p> <p>This Statute will be met as evidenced by;</p> <p>Cross ref. r to 1042</p>	<p>1/22/10</p> <p>completing</p>
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PRINTED: 01/19/2010  
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  R 12/29/2009
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
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I 229	<p>Continued From page 5</p> <p>verification, the GHMRP failed to ensure that staff received effective training on the residents' liquid textures, for one of the four residents in the sample. (Resident #2)</p> <p>The findings include:</p> <p>Cross-refer to I042. Even though the group home had documented providing in-service training to Resident #2's day program staff, observations at lunch on December 29, 2009 indicated that the training had not been effective. The staff used two teaspoons of powdered thickener instead of two tablespoons. The resident's apple juice was not of nectar consistency, as prescribed in her mealtime protocol.</p>	I 229		