

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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W 000	INITIAL COMMENTS A recertification survey was conducted on February 8, 2011 through February 10, 2011. A sample of two clients was selected from a population of four men with various cognitive and intellectual disabilities. Due to condition level deficiencies during the previous recertification survey, this survey was conducted utilizing the full survey process. The findings of the survey were based on observations and interviews with staff and clients in the home, and at one day program, as well as a review of administrative records, including incident reports.	W 000	<p>March 15, 2011</p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 120	483.4 (d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of two of two clients in the sample. (Clients #1 and #2) The findings include: The facility failed to ensure that Client #1 and #2's day program maintained and provided data necessary to monitor their prescribed fluid restrictions, as evidenced below: a. On February 9, 2011, at 10:27 a.m., observations of the mid-morning snack	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>L. Jay D. Smith</i>	TITLE Director of Residential Services	(X6) DATE 3/14/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	<p>Continued From page 1</p> <p>conducted at the day program revealed Client #1 poured 4 ounces of pineapple orange juice into his cup and drank it. Interview with the day program's registered nurse (RN) at approximately 11:00 a.m. revealed that Client #1 was prescribed a 1500 ml fluid restriction diet. Further interview with the RN revealed the day program administered Client #1's fluids in accordance with the nutritionist's 1500 ml fluid restriction breakdown. When asked if there was any documentation available for the client's fluid intake at the day program, the RN revealed there was no documentation in the client's record.</p> <p>Interview with the residential director (RD) on February 9, 2011, at 1:02 p.m. revealed that the day program's nutritionist stated that they do not document Client #1's fluids. The RD's statement was confirmed through interview with facility's RN on February 10, 2011, at approximately 12:10 p.m.</p> <p>On February 10, 2011, at 2:42 p.m., record review revealed a document entitled, "1500 cc Fluid Restriction", dated May 12, 2010, which was created by the group home's dietitian. The document revealed the following breakdown for the day program on Monday through Friday:</p> <p>Mid-Morning Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Lunch: 6 oz (140 cc) Sugar-Free Beverage</p> <p>*Nursing to use 120 cc of fluid with medication pass at the day program)</p>	W 120	<p>W 120</p> <p>The Director of Nursing (DON) and the Director of Residential Services (DRS) will arrange and complete an additional Case Conference with the Day Program Nurse, Nutritionist, and the DDS Service Coordinator to ensure that the Day Program provides and documents the prescribed diet (including any restrictions) to the clients. The DON and DRS will hold a monthly grand round to where documentation will be reviewed to ensure that when Physician Orders change the Day Program Nursing staff are aware, and that day staff are trained on changes when required.</p>	3/25/11
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W 120	<p>Continued From page 2</p> <p>Interview with the qualified mental retardation professional (QMRP) on February 10, 2011, at approximately 5:00 p.m., revealed that a case conference was held at Client #1's day program on August 3, 2010. The case conference was attended by the client's guardian, service coordinator, the facility's interdisciplinary team (QMRP, RD, speech-language pathologist (SLP), registered nurse (RN), nutritionist), and the day program professional team (individual program Plan (PP) coordinator, RN, SLP, nutritionist).</p> <p>On February 10, 2011, at approximately 7:15 p.m., the case conference summary dated August 3, 2010, which was provided by the QMRP revealed the following information:</p> <p>a. The day program nutritionist will administer the fluid intake at the day program.</p> <p>b. The nurse and the nutritionist will oversee the fluid measurements.</p> <p>c. Staff will monitor the client to prevent drinking additional liquids from the soda machine.</p> <p>The case conference summary further documented that the nutritionist assured the QMRP that she would monitor the client's fluid intake daily during lunch. The group home team requested that the day program forward monthly data sheets on the client's fluid intake.</p> <p>b. On February 9, 2011, at 11:22 a.m., interview with Client #2's day staff revealed the nutritionist monitored his fluid intake. Interview with the day program nutritionist on the same day at 11:28 a.m. revealed that the client was prescribed a</p>	W 120		

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W 120	<p>Continued From page 3</p> <p>fluid restricted diet and that he received 240 ml of fluid with his lunch.</p> <p>Record review on February 9, 2011, at 11:45 a.m., revealed a day program quarterly nutrition assessment dated February 2, 2011, that documented that Client #2 was prescribed a 1080 ml fluid restriction per his nutritional assessment from his home dietitian. Further review of the day program quarterly nutritional assessment, however, revealed that it failed to specify how much of the 1080 ml of fluid the client receive at the day program.</p> <p>On February 10, 2011, at 3:10 p.m., record review revealed a document entitled, "1080 cc Fluid Restriction", dated January 31, 2011, which was created by the group home's dietitian. The document revealed the following breakdown for the day program on Monday through Friday:</p> <p>Mid-Morning Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Lunch: 4 oz (120 cc) skim milk</p> <p>Interview with the residential director (RD) on February 9, 2011, at 1:02 p.m., revealed that the day program's nutritionist stated that they do not document Client #2's fluids. The RD's statement was confirmed through interview with facility's RN on February 10, 2011, at approximately 12:10 p.m.</p> <p>It should be noted that further interview with RN revealed that she and the QMRP requested to have data on Client #2's fluid intake sent to the</p>	W 120		

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W 120	Continued From page 4 group home on a monthly basis.	W 120		
W 154	<p>483.4:(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate an injury of unknown origin for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On February 8, 2011, at 4:03 p.m., review of the unusual incidents reports (UIR) revealed an incident dated February 5, 2011, that occurred at 4:14 p.m. The incident revealed that Client #1 was coming out of his bedroom during a fire drill. Staff #1 then noticed blood coming from the client's mouth. The licensed practical nurse (LPN) on duty assessed the client and found his lower lip was cut and bleeding. An ice pack was applied. The client denied any pain and there was no sign of swelling.</p> <p>On February 9, 2011, at approximately approximately 3:30 p.m. interview with the residential director (RD) revealed that when he looked at Client #1's mouth on February 6, 2011,</p>	W 154	<p>W 154</p> <p>The DRS will retain all staff in the home, including the DON, RN Supervisor, LPNs, QDDP (Qualified Developmental Disabilities Professional), and RD on incident management. The DRS will review the IDI incident management protocol, "Investigating Incidents," with all staff; will personally review all incident investigations and summaries and sign off to document review and approval, and will follow up with the QDDP to ensure that complete, signed investigation reports are distributed according to regulation and policy, and that a complete, approved copy is maintained in the clients' records.</p>	3/25/11

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W 154	<p>Continued From page 5</p> <p>he did not observe a cut on the client's lip.</p> <p>On February 10, 2011, at approximately 8:00 p.m., the qualified mental retardation professional (QMRP) provided the surveyors with the internal investigation report which was not signed and dated. The report revealed that Staff #1 walked into the upstairs hallway during a fire drill. As Client #1 was coming out of his bedroom during the drill, Staff #1 noticed blood coming from Client #1's mouth. Staff #1 called the nurse on duty and immediately notified her of the client's injury. The nurse assessed the client's mouth and determined that his lower lip was "cut and bleeding". The nurse then treated the area by applying ice and pressure to the area to stop the bleeding.</p> <p>Continued review of the investigation report on February 10, 2011 at 8:15 p.m. revealed Client #1 stated to the investigator that he did not want to tell what happened and that he did not have to tell her. The report noted that the client stated "I told a lot of people over and over again." The client also alleged that he informed the RD of how his injury occurred.</p> <p>Further review of the investigation report also revealed the the following:</p> <p>a. Staff #2 was on duty with Staff #1 at the time of the incident. Staff #2 was interviewed by the investigator on February 6, 2011 at 12:10 p.m. There was no documented evidence of the interview or written statement.</p> <p>b. There was no documented evidence that the nurse who observed and treated the client's injury</p>	W 154		

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W 154	Continued From page 6 was interviewed. The client's record did include a nursing progress note dated February 5, 2010 (8:00 p.m.) which addressed the injury and first aid treatment to the client's lip.	W 154		
W 156	483.4; 0(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations of injuries of unknown origin to the administrator within five working days of the incident, for one of two clients in the sample. (Client #1) The finding includes: Cross refer to W154. The facility failed to ensure the results of the investigation was reviewed and signed by the administrator within five days.	W 156	W 156 See the response to W 154.	3/25/11
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159		

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W 159	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's qualified mental retardation professional failed to ensure the active treatment program was integrated, coordinated, and monitored for two of two clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross refer to W120. The facility's QMRP failed to ensure that Client #1 and #2's day program maintained and provided data necessary to monitor their prescribed fluid restrictions. 2. Cross refer to 242. The facility's QMRP failed to coordinate services for the implementation of specific measures to address Client #2's hygiene needs. 3. The facility's QMRP failed to coordinate services to ensure that necessary food items were made available in accordance with Clients #1, #2, #3, and #4's therapeutic diets, as evidenced below: <p>On February 9, 2011, at 8:30 a.m. Clients #1, #2, #3, and #4 were observed eating breakfast, which consisted of juice, a whole wheat English muffin, regular strawberry preserves, and turkey ham.</p> <p>On February 9, 2011, at 8:15 a.m. interview with the direct care staff who prepared and served the meal revealed that all clients were to receive the same food, except that Client #1 was to receive a</p>	W 159	<p>W 159</p> <ol style="list-style-type: none"> 1. See response to W 120. 2. See response to W 242. 3. The QDDP will retrain the RD on shopping in accordance with the needs of the clients that are specified in their therapeutic diets. The QDDP will check the weekly shopping receipts to ensure that the RD has purchased items per the diets, and will document the check by signing off on the shopping list. The DRS will review the weekly submission of the shopping list by the QDDP and RD to ensure that it has been reviewed and approved by the QDDP. 	<p>3/25/11</p> <p>3/18/11</p> <p>3/18/11</p>

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W 159	<p>Continued From page 8</p> <p>different type of juice. Further discussion with the direct support staff indicated the clients received all the food that the menu required.</p> <p>On February 9, 2011, at 8:32 a.m. review of the breakfast menu for the day revealed that all clients should have received 1% milk with breakfast. Further review of the menus revealed that in accordance with their therapeutic diets, all of the clients should have received jelly or preserves, (low or reduced sugar). Observation of the refrigerator at 8:34 a.m. revealed that no milk or low/reduced sugar preserves were available to be served.</p> <p>On February 9, 2011, at 9:00 a.m., the residential director acknowledged that milk should have been served with the breakfast meal. Additionally, the RD confirmed that low/reduced sugar preserves or jelly should have been available for the clients at breakfast.</p> <p>4. Cross refer to W249. The facility's QMRP failed to ensure that Clients #1 and #2 received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT).</p> <p>5. Cross refer to W252. The facility's QMRP failed to consistently document Client #2's participation in his training objective designed to increase his independence in meal preparation.</p> <p>6. The facility's QMRP failed to monitor Client #1's fluid intake records to ensure data was collected consistently.</p>	W 159	<p>4. See response to W 249.</p> <p>5. See response to W 252.</p> <p>6. The DON and DRS will retrain the QDDP, RD, LPNs and staff on how to document the FIMS, and the importance of the documentation. The RD will review and sign the data daily, and the QDDP will review and sign the data twice weekly. As soon as either the RD or QDDP note that a staff person has not documented as instructed, immediate retraining will be implemented and documented.</p>	<p>3/18/11</p> <p>3/18/11</p> <p>3/25/11</p>

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W 159	<p>Continued From page 9</p> <p>On February 8, 2011, at 3:30 p.m., Client #1 was observed sitting at the dining table asking the staff for a snack and something to drink. At approximately 3:48 p.m., the RD stated to the surveyors that staff was to monitor the client's 1500 ml fluid restrictions schedule as outlined by the nutritionist. The RD also stated that Client #1 was prescribed a Consistent Carbohydrate Renal Diet. On the same day at 5:27 p.m., the RD poured approximately 8 ounces of beverage in Client #1's cup during dinner time.</p> <p>On February 8, 2011, at 7:20 p.m., observation of the evening medication administration revealed the licensed practical nurse (LPN) poured approximately 120 ccs of water into a large plastic cup for Client #1. On February 9, 2011, at 7:55 a.m., the LPN poured approximately 120 ccs of water into a large plastic cup for Client #1 during the medication administration pass. Later that evening at 5:33 p.m., observation of the dinner meal revealed Client #1 received 8 ounces of beverage during his dinner meal.</p> <p>Review of Client #1's medical records on February 10, 2011, at approximately 12:30 p.m., revealed the client had diagnoses that included diabetes mellitus, hyponatremia, hypertension, and schizophrenia chronic undifferentiated. He was prescribed a 1800 Consistent Carbohydrate, Renal diet with 1500 ml fluid restriction. Further record review revealed a document entitled, "1500 cc Fluid Restriction", dated May 12, 2010, which was created by the dietitian. The document revealed the following breakdown:</p> <p>Breakfast: 4 oz (120 cc) skim Milk</p>	W 159		

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W 159	<p>Continued From page 10</p> <p>4 oz (120 cc) Cranberry Juice</p> <p>Mid-Morning Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Lunch: 8 oz (240 cc) Sugar-Free Beverage</p> <p>Afternoon Snack: 4 oz (20 cc) Sugar-Free Beverage</p> <p>Dinner: 8 oz (240 cc) Sugar-Free Beverage</p> <p>Evening Snack: 6.5 oz (200 cc) Sugar-Free Beverage</p> <p>*Nursing to use 120 cc of fluid with medication pass three times daily totaling 360 cc of fluids.</p> <p>The records additionally revealed Client #1's fluid intake monitoring sheet (FIMS) for February 2011. According the FIMS, there was no documentation for February 8th and 9th, 2011, during the 12:00 a.m. - 8 a.m. and 4:00 p.m. - 12:00 a.m. shift. Further review of the (FIMS) revealed there was no documentation on February 4, 2011 through February 7, 2011, during the 12:00 a.m. - 8 a.m. and 4:00 p.m. to 12 a.m.</p> <p>Interview with the facility's RN on February 10, 2011, at approximately 2:00 p.m., acknowledged that staff were not documenting Client #1's fluid restriction on the FIMS as recommended.</p>	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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W 189	<p>Continued From page 11</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was provided continuing training to enable them to effectively perform duties, for two of two clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <p>[Cross refer to W331] The facility failed to ensure ongoing staff training on the implementing of fluid restrictions for Clients #1 and #2.</p> <p>Interview with the direct support and nursing staff revealed that during the survey, Client #2's fluids were being provided in accordance with the May 27, 2010, 1080 cc breakdown provided by the nutritionist.</p> <p>Review of the training record on February 10, 2011, at 1:20 p.m. revealed staff had received training on fluid restrictions on November 5, and on November 26, 2010. Retraining on the clients' current fluid breakdowns was provided to all staff on duty by the nurses on February 10, 2011. At the time of the survey, however, there was no evidence that the previously provided training had been effective to ensure each staff accurately implemented and timely documented the clients' fluid intake.</p>	W 189	<p>W 189</p> <p>See response to W 159 #6.</p>	3/25/11
W 242	483.44(c)(6)(iii) INDIVIDUAL PROGRAM PLAN	W 242		

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W 242	<p>Continued From page 12</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) included training in personal skills essential for independence, until it has been demonstrated that the client is developmentally incapable of acquiring them, for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Evening observation on February 8, 2011, at 4:11 p.m., revealed Client #2 appeared to be wearing dentures. Interview with direct support staff on February 9, 2011, at 3:30 p.m. revealed that Client #2 wore partial dentures, however had a few remaining natural teeth. Staff indicated that the client was able to brush his natural teeth, however needed to be monitored for thoroughness. Staff also revealed that the client was supervised during care and cleaning of his dentures.</p> <p>On February 9, 2011, at 9:45 a.m., review of dental consultation dated September 22, 2010 revealed the dentist recommended that Client #2</p>	W 242	<p>W 242</p> <p>The QDDP will produce a dental hygiene program to support the client to improve and maintain dental health per the Dentist's recommendations. The DRS will track the performance of the QDDP, RD, and staff to ensure that the programming and IPPs are properly formulated, trained, and effectively implemented.</p>	3/18/11
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W 242	Continued From page 13 have root canals and crowns for teeth #22 and #27, as well as new dentures. The root canals were performed on November 17, 2010. The dental assessment conducted on the same date revealed diagnoses of generalized plaque, calculus and gingival inflammation. The dentist noted that the client had "pocket depth of 4 mm and higher, which indicated gum disease was present. The dentist recommended the client to have assistance with brushing two times a day, flossing of natural teeth, and to take advantage of periodontal treatments." Further review of the client's medical record at 2:15 p.m. on the same day, revealed that due to the client's cognitive and adaptive deficits, he had a potential for poor oral hygiene. Interview with the QMRP and the RD on February 10, 2010, at 4:42 p.m. revealed that Client #2 was recommended to have a dental hygiene program at his individual support plan (ISP) meeting dated June 2010. Review of the client's individual program plan (IPP) on February 10, 2011, at approximately 3:40 p.m., and further discussion with the QMRP and RD revealed that Client #2 did not have a dental hygiene program. At the time of the survey, however, the recommended dental training/supervision program had not been formally implemented.	W 242		
W 249	483.420(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active	W 249		

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W 249	<p>Continued From page 14</p> <p>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, staff interview and record review, the facility failed to ensure that two of two clients in the sample received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT). (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. On February 8, 2011, at 3:50 p.m., observation of Client #2 revealed he was able of respond appropriately when questioned by direct support staff. At 4:07 p.m., interview with staff revealed Client #2 was cooperative and enjoyed helping out around the house.</p> <p>On February 9, 2011, at 1:09 p.m., review of Client #'s individual support plan (ISP) dated June 24 2010, revealed the IDT recommended several goals to enhance the client's level of functioning in the community. The IPP included the following goals (1) to increase his communication skills and (2) to increase his home management skills, respectively:</p> <p>Two times week, Client #2 will complete the steps for travel on Metro using a pre-selected route with 80% accuracy per session for six consecutive months.</p>	W 249	<p>W249</p> <p>1. The QDDP will ensure that the RD completes a weekly travel schedule for the client, provides cash for travel, and ensures that the staff and the client implement and document the IPP. The DRS will review at least bi-weekly to ensure compliance.</p>	3/18/11

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W 249	<p>Continued From page 15</p> <p>Review of the corresponding active treatment data revealed that Client #2 traveled on the Metro on February 1, 2011. Interview with the residential director (RD) on February 9, 2011, at 3:22 p.m. failed to confirm that the client had traveled on the Metro after February 1, 2010.</p> <p>2. On February 8, 2011, at 5:23 p.m., Client #1 was observed sitting at the dining table waiting for his dinner. At 5:27 p.m., the residential director (RD) was observed to pour approximately eight (8) ounces of beverage into the client's cup. The client was not observed to measure his beverage. On February 9, 2011, at 5:53 p.m., the direct support person (DSP) poured 8 ounces of the beverage from the measuring cup into Client #1's regular cup while the client sat at the dining table for dinner. Again, the client was not observed to measure his beverage.</p> <p>Interview with the RD on February 10, 2011, at approximately 10:05 a.m., revealed that the client had a program objective to measure his fluids three (3) times a week during dinner time.</p> <p>Record verification of Client #1's IPP dated September 5, 2010, on February 10, 2011, at approximately 10:30 a.m., revealed three (3) days a week, the client when, "given physical assistance, will measure his approved fluid intake of 8 ounces for dinner with 75% accuracy for 12 consecutive months."</p> <p>Review of the February 2011, data collection sheets on February 10, 2010, at approximately 11:00 a.m., revealed staff last documented the objective on February 3, 2011. This was</p>	W 249	<p>2. The RD will review and sign off on IPP implementation and documentation daily, and the QDDP will review and sign the data collection twice weekly. As soon as either the RD or QDDP note that a staff person has not documented as instructed, immediate retraining will be implemented and documented.</p>	3/8/11
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W 249	Continued From page 16	W 249		
W 252	<p>confined through interview with the RD on the same day at approximately 11:20 a.m.</p> <p>483.410(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure data was collected in a manner to accurately measure progress toward the individual program plan (IPP) objectives for one of two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>The facility failed to consistently document Client #2's participation in his training objective designed to increase his independence in meal preparation, as evidenced below:</p> <p>On February 8, 2011, at 4:55 p.m., Client #2 was observed assisting staff with dinner preparation by washing vegetables for salad. On February 9, 2011, at approximately 5:00 P.M., the client was observed removing items from cabinets and obtaining cooking utensils for staff. Interview with direct support staff on February 8, 2011, at 4:59 p.m., revealed the client had a training objective to assist with the preparation of the dinner meal several times a week.</p>	W 252	<p>W 252</p> <p>See response to W 249.</p>	3/18/11

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W 252	Continued From page 17 On February 9, 2011, at 3:31 p.m., review of Client #2's IPP objectives for February 2011, revealed a goal to improve his activities of daily living skills. The corresponding objective stated, "Three times a week, the [Client] will assist staff to prepare dinner with 40% independence of the opportunities provided for six consecutive months". Further review of the data collection form for the objective, however, revealed no data was recorded after February 3, 2011.	W 252		
W 322	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 preventive health services, for two of two clients in the sample. (Clients #1 and #2) The finding includes: Cross refer to W120 and W331. The facility failed to ensure documentation was obtained/maintained for each clients fluid restriction and failed to ensure each client fluid restriction was consistently observed.	W 322	W 322 See response to W120.	3/25/11
W 325	482.461(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.	W 325		

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W 325	Continued From page 18 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure routine laboratory studies were conducted, for one of the two clients (Client #1) included in the sample. The finding includes: The facility failed to ensure that Client #2's serum electrolytes were monitored at the prescribed frequency, as evidenced below: On February 10, 2011 at 3:10 p.m., record review revealed a document entitled, "1080 cc Fluid Restriction", dated January 31, 2011, which was created by the group home's dietitian. This document provided a breakdown on how the client fluid's were to be provided each day. On February 10, 2011, at 6:05 p.m., review of Client #2's medical problem list revealed it included "Hyponatremia - resolved on fluid restriction and to continue the 1080 cc fluid restriction to prevent the return of hyponatremia. The client's current physician's order dated December 1, 2010 revealed a lab order (initial date May 14, 2009) for electrolyte monitoring every three months. Continued record review revealed laboratory reports (including electrolytes) dated May 28, 2010 and November 3, 2010. Interview with the RN on February 10, 2011 at 6:42 p.m. acknowledged that the labs were not obtained every three months as ordered.	W 325	W325 The DON and DRS will ensure that a monthly grand round is held to track and verify all medical and clinical needs, and to ensure that each need is addressed, including taking labs every three months for electrolyte monitoring.	3/25/11
W 331	483.460(c) NURSING SERVICES	W 331		

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W 331	<p>Continued From page 19</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of two clients in the sample. (Clients: #1 and #2)</p> <p>The findings include:</p> <p>1. The facility failed to ensure Client #2's received medication were documented timely after administration, as evidenced below:</p> <p>On February 8, 2011, at 6:26 p.m. Client #2 was administered Polyethylene Glycol mixed in water and Famotidine 20 mg, 1 tab by the medication nurse (LPN). Interview with the LPN at 6:33 p.m., revealed the medications were prescribed to prevent constipation and to prevent gastric distress.</p> <p>Record review on February 8, 2011, at 8:15 p.m., revealed administration of the Polyethylene Glycol mixed in water and Famotidine 20 mg, 1 tab to Client #2 was not documented on the medication administration record (MAR). Further discussion with the LPN on February 9, 2011 at 4:49 p.m. acknowledged that the administration of the aforementioned medications had not been documented.</p> <p>2. [Cross refer to W371.] The facility's nursing services failed to ensure that Client #1 was given the opportunity to fully participate in his self-</p>	W 331	<p>W 331</p> <p>1. The DON will retrain the medication nurse on the requirement to document all medicines administered. The DON will ensure that the RN monitors the MAR and signs at least monthly to ensure that nursing documentation is complete and accurate.</p> <p>2. See response to W 371.</p>	3/18/11
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W 331	<p>Continued From page 20 medication program.</p> <p>3. The facility's nursing services failed to ensure Client #2 received fluids in accordance with his outlined fluid restriction, as evidenced below:</p> <p>On February 8, 2011, at 4:00 p.m., Client #2 was observed sitting at the dining table eating a snack which included approximately 8 ounces of juice. During the snack, the RD informed the surveyors that the client's physician's orders included a 1080cc fluid restriction outlined by the nutritionist. On the same day at 5:29 p.m., the RD poured approximately 8 ounces of beverage into Client #2's cup during dinner time. Additionally, the client received Boost Plus 240cc with his dinner.</p> <p>On February 8, 2011, at 6:26 p.m., observation of the evening medication administration revealed the licensed practical nurse (LPN) poured approximately 120 ccs of water into a plastic cup for Client #2, which he drank after his pills.</p> <p>On February 10, 2011 at 3:10 p.m., record review revealed a document entitled, "1080 cc Fluid Restriction", dated January 31, 2011, which was created by the group home's dietitian. This documented provided a breakdown on how the client fluids were to be provided on each day.</p> <p>Breakfast: 8 oz (240 cc) Skim Milk</p> <p>Mid-Morning Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Lunch:</p>	W 331	<p>3. The DON and DRS will ensure that all staff, including nurses, are retrained on the client's fluid restrictions. The RD and any LPN or RN who is on duty will monitor and intervene/redirect staff and the client if the fluids given at mealtime or snack time do not meet the plan developed by the Nutritionist. The DON and the DRS will observe meals/snacks/med pass at least twice monthly to ensure compliance and to provide immediate retraining as needed for three months. After three months the RN Supervisor and the QDDP will provide such monitoring and retraining to sustain corrective measures.</p>	3/25/11
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W 331	Continued from page 21 4 oz (120 cc) Skim Milk Afternoon Snack: 4 oz (120 cc) Sugar-Free Beverage Dinner: 8 ounces Boost Plus Beverage Evening Snack: 4 oz (120 cc) Skim Milk *Nursing to use 60 cc of fluid with medication pass twice times daily totaling 120 cc of fluids. At the time of the survey, the facility's nursing services failed to ensure Client #2's fluid restriction was provided as indicated.	W 331		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that each client participated in a self-medication training program for one of two clients in the sample. (Client #1) The findings include: On February 8, 2011, at 7:20 p.m. observation of the evening medication administration revealed	W 371	The DON will retrain all medication nurses on the proper implementation and documentation of the clients' self-medication IPPs. The DON will track performance by observing a medication pass at least once every two weeks, and providing immediate retraining as necessary.	3/25/11

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W 371	Continued From page 22 the licensed practical nurse (LPN) poured approximately 120 ccs of water into a large plastic cup for Client #1. The nurse punched the client's pills into a medication cup, passed the medication cup to him, and then informed him that it was time to take his medications. The client independently consumed the pills, drank all of the water from the cup, and put the pill cup into the trash. Interview with the medication nurse on the same day, at 7:25 p.m. revealed the client had previously participated in the administration of his own medications, however had a problem with dropping his pills. On February 9, 2011, at approximately 4:45 p.m., review of Client #1's individual program plan (IPP) dated September 5, 2010, revealed an objective that stated, "with verbal prompts, the client will participate in self-medication administration for 75% of trial periods". Further review indicated the client's self-medication program was outlined as follows: a. Identify personal medication container; b. Pour beverage into cup; c. Accept medications and d. Put medication cup in trash. At the time of the survey, there was no evidence that Client #1 was given the opportunity to fully participate in his self-medication program.	W 371			
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440			

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

PRINTED: 03/04/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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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 440	<p>Continued From page 23</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)</p> <p>The finding includes:</p> <p>The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below:</p> <p>On February 8, 2011, at 5:50 p.m., interview with the residential director (RD) revealed that there were three designated shifts (6:00 AM -2:30 PM; 2:00 PM -10:30 PM and 10:00 PM - 6:30 AM) Monday through Friday. Further interview revealed that there were two designated shifts (6:00 AM - 6:30 PM and 6:00 PM - 6:30 AM) for the weekend (Saturday/Sunday).</p> <p>Review of the facility's fire drill log records on the same day at approximately 5:58 p.m. revealed no documented drills were held during the weekday overnight shift (10:00 PM - 6:30 AM) from April 2010 through June 2010. In addition, there were no documented fire drills held during the weekend evening shifts (6:00 PM - 6:30 AM) from July 2010 through December 2010. This was acknowledged by the facility's house manager (HM) on February 10, 2011, at 12:07 p.m.</p>	W 440	<p>W440</p> <p>The RD and QDDP will hold scheduled and unscheduled evacuation drills on each shift four times annually. The DRS will establish a tracking mechanism to ensure compliance.</p>	3/14/11
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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1000	INITIAL COMMENTS A licensure survey was initiated on February 8, 2011 through February 10, 2011. A sample of two residents was selected from a population of four men with various cognitive and intellectual disabilities. Due to condition level deficiencies during the previous recertification survey, this survey was conducted utilizing the full survey process. The findings of the survey were based on observations and interviews with staff and residents in the home and at one day program, as well as a review of administrative records, including incident reports.	1000		
1082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disability (GHPID) failed to equip all bathrooms used by residents with paper towels and paper cups, for four of four residents of the facility. (Residents #1, #2, #3 and #4) The finding includes: On February 10, 2011, at 2:32 p.m., there were no paper cups, cup dispenser, paper towel, or towel dispenser observed in the master	1082	I 082 The QDDP will do a weekly walk-through at the home to check for all environmental concerns, including the proper stocking of paper cups and paper towels in each bathroom. The QDDP will document the walk-through each week, along with instructions provided to the RD and staff.	3/16/11

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[Signature] Director of Residential Services

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

DATE 3/14/11

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1082	Continued From page 1 bathroom, which was adjacent to the bedroom of Residents #1 and #2. The residential director (RD), who was present during the environmental walk-through, acknowledged that there were no paper cups, paper cup dispenser, paper towel or paper towel dispenser observed in the master bathroom.	1082		
1090	3504. 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, interview, and record review the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure the environment was maintained in a safe clean orderly to meet the needs for, two of four residents in the survey. (Residents #1 and #4) The findings include: On February 10, 2011, beginning at 2:16 p.m., observations were conducted of the environment. The surveyor was escorted through the facility by the residential director (RD) who acknowledged the following concerns: 1. Resident #1's shoes were stored in a laundry basket in his closet. Other pairs of shoes were stored directly on floor of the client's closet. Resident #4 shoes were also stored on the floor	1090	I 090 1. The RD will devise appropriate storage for and easy access to the clients' shoes.	3/18/11

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1090	Continued From page 2 of his closet. The shoes were not easily accessible to the residents. 2. Resident #1's chest of drawers contained a drawer, which had a partially detached bottom. 3. One of two lights in the fixtures located at the basement exit was not operable.	1090	2. The Maintenance Division will repair the drawer. 3. The Maintenance Division will ensure the light fixture is repaired.	3/18/11 3/18/11
1135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts for four of four residents residing in the GHPID. (Residents #1, #2, #3, and #4) The finding includes: The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On February 8, 2011, at 5:50 p.m., interview with the house manager (HM) revealed that there were three designated shifts (6:00 AM - 2:30 PM; 2:00 PM - 10:30 PM and 10:00 PM - 6:30 AM) Monday through Friday. Further interview revealed that there were two designated shifts (6:00 AM - 6:30 PM and 6:00 PM - 6:30 AM) for the weekend (Saturday/Sunday).	1135	I 135 See response to federal deficiency W 440.	3/17/11

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1135	Continued From page 3 Review of the GHPID's fire drill log records on the same day at approximately 5:58 p.m. revealed that no drills were held during the weekday overnight shift (10:00 PM - 6:30 AM) from April 2010 through June 2010. In addition, there were no fire drills held during the weekend evening shifts (6:00 PM - 6:30 AM) from July 2010 through December 2010. This was acknowledged by the GHPID's house manager (HM) on February 10, 2011, at 12:07 p.m.	1135		
1180	3508. ADMINISTRATIVE SUPPORT Each CHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the active treatment program was integrated, coordinated, and monitored for two of two residents in the sample. (Residents #1 and #2) The findings include: 1. Cross refer to federal deficiency report citation W120. The GHPID's QMRP failed to ensure that Resident #1 and #2's day program maintained and provided data necessary to monitor their prescribed fluid restrictions: 2. Cross refer to W242 federal deficiency report citation W242. The GHPID's QMRP failed to coordinate services for the implementation of specific measures to address Resident #2's oral	1180	1180 1. See response to federal deficiency W 120. 2. See response to federal deficiency W 242.	3/25/11 3/18/11

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1180	<p>Continued From page 4</p> <p>hygiene needs.</p> <p>3. The facility's QMRP failed to coordinate services to ensure that necessary food items were made available in accordance with Residents #1, #2, #3, and #4's therapeutic diets, as evidenced below:</p> <p>On February 9, 2011, at 8:30 a.m. Residents #1, #2, #3 and #4 were observed eating breakfast, which consisted of juice, a whole wheat English muffin, regular strawberry preserves, and turkey ham.</p> <p>On February 9, 2011, at 8:15 a.m. interview with the direct care staff who prepared and served the meal revealed that all residents were to receive the same food, except that Resident #1 was to receive a different type of juice. Further discussion with the direct support staff indicated the clients received all the food that the menu required.</p> <p>On February 9, 2011, at 8:32 a.m. review of the breakfast menu for the day revealed that all residents should have received 1% milk with breakfast. Further review of the menus revealed that in accordance with their therapeutic diets, all of the residents should have received jelly or preserves, (low or reduced sugar). Observation of the refrigerator at 8:34 a.m. revealed that no milk or low/reduced sugar preserves were available to be served.</p> <p>On February 9, 2011, at 9:00 a.m., the residential director acknowledged that milk should have been served with the breakfast meal. Additionally, the RD confirmed that</p>	1180	3. See response to federal deficiency W 159 #3.	3/18/11

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I 180	<p>Continued From page 5</p> <p>low/reduced sugar preserves or jelly should have been available for the clients at breakfast.</p> <p>4. Cross refer to federal deficiency report citation W249. The facility's QMRP failed to ensure that Residents #1 and #2 received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT).</p> <p>5. Cross refer to federal deficiency report citation W252. The facility's QMRP failed to consistently document Resident #2's participation in his training objective designed to increase his independence in meal preparation.</p> <p>6. The GHPID's QMRP failed to monitor Resident #1's fluid intake records to ensure data was collected consistently.</p> <p>On February 8, 2011, at 3:30 p.m., Resident #1 was observed sitting at the dining table asking the staff for a snack and something to drink. At approximately 3:48 p.m., the RD stated to the surveyors that staff was to monitor the resident's 1500 ml fluid restrictions schedule as outlined by the nutritionist. The RD also stated that Resident #1 was prescribed a Consistent Carbohydrate Renal Diet. On the same day at 5:27 p.m., the RD poured approximately 8 ounces of beverage in Resident #1's cup during dinner time.</p> <p>On February 8, 2011, at 7:20 p.m., observation of the evening medication administration revealed the licensed practical nurse (LPN) poured approximately 120 ccs of water into a large plastic cup for Resident #1. On February 9, 2011, at 7:55 a.m., the LPN poured</p>	I 180	<p>4. See response to federal deficiency W 249. 3/18/11</p> <p>5. See response to federal deficiency W 252. 3/18/11</p> <p>6. See response to federal deficiencies W 159, #6 and W 242. 3/25/11</p>	

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I 180	<p>Continued From page 6</p> <p>approximately 120 ccs of water into a large plastic cup for Resident #1 during the medication administration pass. Later that evening at 5:33 p.m., observation of the dinner meal revealed Resident #1 received 8 ounces of beverage during his dinner meal.</p> <p>Review of Resident #1's medical records on February 10, 2011, at approximately 12:30 p.m., revealed the resident had diagnoses that included diabetes mellitus, hyponatremia, hypertension, and schizophrenia chronic undifferentiated. He was prescribed a 1500 Consistent Carbohydrate, Renal diet with 1500 ml fluid restriction. Further record review revealed a document entitled, "1500 cc Fluid Restriction", dated May 12, 2010, which was created by the dietitian. The document revealed the following breakdown:</p> <p>Breakfast: 4 oz (120 cc) skim Milk 4 oz (120 cc) Cranberry Juice</p> <p>Mid-Morning Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Lunch: 8 oz (240 cc) Sugar-Free Beverage</p> <p>Afternoon Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Dinner: 8 oz (240 cc) Sugar-Free Beverage</p> <p>Evening Snack: 6.5 oz (200 cc) Sugar-Free Beverage</p>	I 180			

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1180	<p>Continued From page 7</p> <p>*Nursing to use 120 cc of fluid with medication pass three times daily totaling 360 cc of fluids.</p> <p>The records additionally revealed Resident #1's fluid intake monitoring sheet (FIMS) for February 2011. According the FIMS, there was no documentation for February 8th and 9th, 2011, during the 12:00 a.m. - 8 a.m. and 4:00 p.m. - 12:00 a.m. shift. Further review of the (FIMS) revealed there was no documentation on February 4, 2011 through February 7, 2011, during the 12:00 a.m. - 8 a.m. and 4:00 p.m. to 12 a.m.</p> <p>Interview with the GHPID's RN on February 10, 2011, at approximately 2:00 p.m., acknowledged that staff were not documenting Resident #1's fluid restriction on the FIMS as recommended.</p> <p>Interview with the QMRP and the residential director (RD) on February 10, 2010, at 4:42 p.m. acknowledged that Resident #2 had a dental hygiene training program prior to his new ISP. At the time of the survey, however, there was no evidence that specific measures had been implemented to address the resident's dental hygiene of his remaining natural teeth after the June 2010 ISP.</p> <p>3. [Cross refer to W249.] The GHPID's QMRP failed to ensure that Residents #1 and #2 received continuous active treatment to support achievement of individual program plan (IPP)</p>	1180	<p>3. See response to federal deficiency W 249.</p>	3/18/11
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I 180	Continued From page 8 objectives identified by the interdisciplinary team (IDT). 5. [Cross refer to W252.] The GHPID's QMRP failed to consistently document Resident #2's participation in his training objective designed to increase his independence in meal preparation.	I 180	5. See response to federal deficiency W 252.	3/18/11
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 observation, interview and record review the Group Home for Persons with Intellectual Disabilities (GHPID) failed to provide professional services that included treatment services, and services designed to prevent deterioration or further loss of function by the resident, for two of two residents in the sample. (Residents #1 and #2) The findings include: Based on observation, interview, and record review the GHPID failed to ensure nursing services were provided in accordance with the needs for, two of two clients in the sample. (Residents #1 and #2) The findings include:	I 401		

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I 401	Continued From page 9 1. The GHPID failed to ensure Resident #2's received medication were documented timely after administration, as evidenced below: On February 8, 2011, at 6:26 p.m. Resident #2 was administered Polyethylene Glycol mixed in water and Famotidine 20 mg, 1 tab by the medication nurse (LPN). Interview with the LPN at 6:31 p.m., revealed the medications were prescribed to prevent constipation and to prevent gastric distress. Record review on February 8, 2011, at 8:15 p.m., revealed administration of the Polyethylene Glycol mixed in water and Famotidine 20 mg, 1 tab to Resident #2 was not documented on the medication administration record (MAR). Further discussion with the LPN on February 9, 2011 at 4:49 p.m. acknowledged that the administration of the aforementioned medications had not been documented. 2. [Cross refer to W371.] The GHPID's nursing services failed to ensure that Resident #1 was given the opportunity to fully participate in his self-medication program. 3. The GHPID's nursing services failed to ensure Resident #2 received fluids in accordance with his outlined fluid restriction, as evidenced below: On February 8, 2011, at 4:00 p.m., Resident #2 was observed sitting at the dining table eating a snack which included approximately 8 ounces of juice. During the snack, the RD informed the surveyors that the client's physician's orders included a 1080cc fluid restriction outlined by the nutritionist. On the same day at 8:29 p.m., the	I 401	I 401 1. See response to federal deficiency W 331 #1. 2. See response to federal deficiency W 371. 3. See response to federal deficiency 331 #3.	3/18/11 3/25/11 3/25/11

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I 401	<p>Continued From page 10</p> <p>RD poured approximately 8 ounces of beverage into Resident #2's cup during dinner time. Additionally, the resident received Boost Plus 240cc with his dinner.</p> <p>On February 8, 2011, at 6:26 p.m., observation of the evening medication administration revealed the licensed practical nurse (LPN) poured approximately 120 ccs of water into a plastic cup for Resident #2, which he drank after his pills.</p> <p>On February 10, 2011 at 3:10 p.m., record review revealed a document entitled, "1080 cc Fluid Restriction", dated January 31, 2011, which was created by the group home's dietitian. This documented provided a breakdown on how the resident fluids were to be provided on each day.</p> <p>Breakfast: 8 oz (240 cc) Skim Milk</p> <p>Mid-Morning Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Lunch: 4 oz (120 cc) Skim Milk</p> <p>Afternoon Snack: 4 oz (120 cc) Sugar-Free Beverage</p> <p>Dinner: 8 ounces Boost Plus Beverage</p> <p>Evening Snack: 4 oz (120 cc) Skim Milk</p> <p>*Nursing to use 60 cc of fluid with medication</p>	I 401		
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1401	Continued From page 11 pass twice times daily totaling 120 cc of fluids. At the time of the survey, the GHPID's nursing services failed to ensure Resident #2's fluid restriction was provided as indicated.	1401		
1422	3521.1 HABILITATION AND TRAINING Each SHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that two of two residents in the sample received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT). (Residents #1 and #2) The findings include: The findings include: 1. On February 8, 2011, at 3:50 p.m., observation of Resident #2 revealed he was able of respond appropriately when questioned by direct support staff. At 4:07 p.m., interview with staff revealed Resident #2 was cooperative and enjoyed helping out around the house. On February 9, 2011, at 1:09 p.m., review of Resident #2's individual support plan (ISP) dated June 14, 2010, revealed the IDT recommended several goals to enhance the Resident's level of functioning in the community. The IPP included	1422	I 422 1. See response to federal deficiency W 249 #1.	3/18/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER (OR SUPPLIER) INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018		
(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 422	<p>Continued From page 12</p> <p>the following goals (1) to increase his communication skills and (2) to increase his home management skills, respectively:</p> <p>Two times week, Resident #2 will complete the steps for travel on Metro using a pre-selected route with 80% accuracy per session for six consecutive months.</p> <p>Review of the corresponding active treatment data revealed that Resident #2 traveled on the Metro on February 1, 2011. Interview with the residential director (RD) on February 9, 2011, at 3:22 p.m. failed to confirm that the Resident had traveled on the Metro after February 1, 2010.</p> <p>2. On February 8, 2011, at 5:23 p.m., Resident #1 was observed sitting at the dining table waiting for his dinner. At 5:27 p.m., the residential director (RD) was observed to pour approximately eight (8) ounces of beverage into the Resident's cup. The Resident was not observed to measure his beverage. On February 9, 2011, at 5:53 p.m., the direct support person (DSP) poured 8 ounces of the beverage from the measuring cup into Resident #1's regular cup while the Resident sat at the dining table for dinner. Again, the Resident was not observed to measure his beverage.</p> <p>Interview with the RD on February 10, 2011, at approximately 10:05 a.m., revealed that the Resident had a program objective to measure his fluids three (3) times a week during dinner time.</p> <p>Record verification of Resident #1's IPP dated September 5, 2010, on February 10, 2011, at approximately 10:30 a.m., revealed three (3)</p>	I 422	2. See response to federal deficiency W 249 #2.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2011
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018		
(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
1422	Continued From page 13 days a week, the Resident when," given physical assistance, will measure his approved fluid intake of 8 ounces for dinner with 75% accuracy for 12 consecutive months." Review of the February 2011, data collection sheets on February 10, 2010, at approximately 11:00 a.m., revealed staff last documented the objective on February 3, 2011. This was confirmed through interview with the RD on the same day at approximately 11:20 a.m.	1422		