

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

PRINTED: 05/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032
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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	INITIAL COMMENTS Surveyor: 12301 A recertification survey was conducted from 4/22/2010 through 4/23/2010. The survey was completed utilizing the fundamental survey process.	W 000	<i>Received via to</i> GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 W120	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review, the contracted pharmacy failed to ensure that medication labels coincided with the current physician's orders for two of the six clients residing in the facility. (Clients #3 and #6) The findings include: 1. Observation of the administration of Client #3's medications on 4/22/2010, at 7:16 p.m., revealed that he received generic Debrox, 10 drops in his left ear. Interview with the medication nurse, the licensed	W 120	This Standard will be met as evidenced by: Follow up actions have been taken to address the medications prescribed for #3 and #6. RN conducted additional training on ordering of new medications from the pharmacy and matching the information to ensure it is consistent with the prescribed physician orders. The RN will continue to check medications, physician orders on a routine basis and provide direction to the LPN's as needed to ensure ongoing compliance with this standard. #1 and #2 reference above response.	5.5.10 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>MARLY BROWN</i>	TITLE DRS	(X6) DATE 5-27-10
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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>practical nurse (LPN) on 4/22/10, at 7:20 p.m., revealed that the ear drops were recommended by the ear nose and throat clinic on 4/15/2010, to further soften the wax in Client #3's ear.</p> <p>The review of the label on the ear drops on 4/22/10, at 7:50 p.m., revealed instructions to administer Client #3 five (5) drops of the medication in each ear twice daily. According to the most recent physician's order, dated April 15, 2010, the client was prescribed to receive "Debrox 10 drops daily in left ear x 14 days" for ear wax removal.</p> <p>At the time of the survey, there was no evidence the pharmacy had ensured that the label on Client #3's ear drops corresponded with the current physician's order.</p> <p>2. Observation of the administration of Client #6's medications on April 22, 2010, at 7:20 p.m., revealed that he received generic ear drops, 2 drops in both ears.</p> <p>Interview with the medication nurse and the LPN on 4/22/10, at 7:24 p.m., revealed that the drops were prescribed by the primary care physician to the keep the wax in Client #6's ears soft.</p> <p>The review of the label on the ear drops on 4/22/10, at 7:52 p.m., revealed instructions to administer Client #6 five (5) drops of the medication in each ear twice daily for the first five days in the month. The physician's order dated 3/1/2010, included an order for "Debrox 6.5% drops: 2 drops in both ears, 2 times a week for cerumen impaction." The 4/2010 medication administration record also documented a</p>	W 120		

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W 120	Continued From page 2 physician's order dated 3/10/2010, for "Eardrops (generic debrox) 6.5 %, Instill 2 drops in each ear 2 times a week for cerumen impaction."	W 120		
W 159	At the time of the survey, however, there was no evidence the pharmacy had ensured that the label on Client #6's ear drops corresponded with the current physician's medication order. 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. This STANDARD is not met as evidenced by: Surveyor: 12301 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 one of the three clients in the sample. (Client #1) The findings include: 1. The facility's QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP), included a data collection system directly related to the outcome of the ambulation objective for Client #1. [See W237] 2. The facility's QMRP failed to coordinate and monitor services to ensure the timely replacement of Client #1's wheelchair cushion. [See W436]	W 159	W159 This Standard will be met as evidenced by: 1. Reference response to W237. 2. Reference response to W436.	5-21-10 ongoing

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W 237	<p>483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.</p> <p>This STANDARD is not met as evidenced by: Survivor: 12301</p> <p>Based on observation, interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the Individual program plan (IPP) included a data collection system directly related to the outcome of the objective for one of the three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On 4/22/10, at 10:40 a.m., Client #1's instructor was observed rolling him in a wheelchair from where he ate his snack in the treatment room to the sitting area, which was located approximately 30 feet away. The instructor then asked the client to stand up from his wheel chair and assisted him to ambulate approximately 15 feet to the couch. At that time, the client sat down on the couch.</p> <p>Interview with the instructor during the aforementioned observation revealed that he encourages the client to walk every day because he does not like to walk as much as " he use to walk. "</p> <p>On 4/22/10, at 3:57 p.m., two direct care staff were observed unloading Client #1 from the van into his wheelchair when he returned at the group</p>	W 237	<p>W237</p> <p>This Standard will be met as evidenced by:</p> <p>The program objective for #1 will be written to provide clear directions for staff as well as the frequency of program implementation and data collection information. Staff training will be conducted to ensure accurate monitoring of the person's progress. QMRP and consultant will monitor measure performance levels and make revisions as needed.</p>	5-21-10 Ongoing	

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W 237	<p>Continued From page 4</p> <p>home from the day program. Staff then wheeled the client into the facility. The client proceeded to propel himself in the wheelchair, using his feet to move himself down the hallway at a moderate pace. At 4:40 p.m., the client was observed wheeling himself away from the keyboard, and starting down the hallway again using his feet to propel himself. A staff followed him, and asked him if he wanted to walk. The staff then assisted the client to stand up from his wheelchair, however, the client turned back toward his wheelchair and was assisted to sit back down.</p> <p>Upon Client #1's return from the day program on 4/23/10, he was observed being assisted to walk into the facility from the van.</p> <p>Interview with staff on 4/22/10, at 4:17 p.m., revealed Client #1 should walk as much as possible and that he has a training objective to walk daily. Interview with the qualified mental retardation professional (QMRP) on 4/23/10, at approximately 3:15 p.m., indicated that during the current ISP year, the client's distance tolerated during ambulation had progressed from 50 to 150 feet daily.</p> <p>Record review on 4/23/10, at 4:30 p.m., revealed Client #1's individual plan plan (IPP) included a goal dated 6/08/09, "To improve ambulation endurance." The objective stated, "Given stand-by assistance, Mr. [Client] will ambulate 150 feet, 3 days a week, for 6 consecutive months. The review of program data for 4/2010 indicated that on each day documented, the client ambulated 150 feet. The review of the skill acquisition revealed that the training instructions were: "Given standby assistance, Mr. [Client] will ambulate 150 feet, 3 days a week, for 6</p>	W 237			

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W 237	Continued From page 5 consecutive months." At the time of the survey, the record, however, failed to specify how staff would be able to determine when the client had ambulated 150 feet. At the time of the survey, there was no evidence the training program was designed to provide specific information to provide accurate monitoring of the client's progress in the training objective.	W 237		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and the record review the facility's nursing services failed to coordinate services for two of the six clients residing in the facility. (Clients #3 and #6) The findings include: 1. [Cross refer to W120]. The facility's nursing services failed to coordinate services to ensure the timely receipt of medication labels corresponding to the physicians orders for Clients #3 and #6 as evidenced below: Medication administration observations on 4/22/10, at 7:16 p.m., and 7:28 p.m. respectively, revealed Client #3 and Client #6 received ear drops. The review of the physician's orders on 4/22/10, at approximately 7:55 p.m., revealed that the ear	W 331	W331 This Standard will be met as evidenced by: 1. Cross reference response to W120. 2. Cross reference W120.	5.14.10 OPIC/OLIC

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W 331	<p>Continued From page 6</p> <p>drops had been administered as prescribed by the primary care physician. The review of the labels on the ear drops revealed, however, that they had not been changed to reflect the currently prescribed dosages and frequency of the ear drops, to correspond with the physician's orders.</p> <p>Interview with the nurse during the medication administration confirmed that the physician had changed the orders to reflect the amount and frequency of the ear drops which were received by Clients #3 and #6. Interview with the RN revealed that the policy was to send the new medication orders to the pharmacy, whenever a medication order changed. At the time of the survey, however, there was no evidence that the coordination/follow-up had been effective to ensure that the pharmacy provided eardrops labeled in accordance with the currently prescribed dosage and frequency of the medication.</p> <p>2. [Cross refer to W120] The facility failed to ensure that Client #3 and #6 were provided privacy during the administration of ear drops as evidenced below.</p> <p>On 4/22/10, between 7:16 p.m. and 7:28 p.m., the LPN nurse administered ear drops for Clients #3 and #6, while they were in the bedroom together.</p> <p>Interview with the RN on 4/22/10, at approximately 7:55 p.m., revealed Client #3 and #6 should have each been alone when their ear drops were administered by the nurse.</p> <p>At the time of the survey, there was no evidence the facility had ensure that each client had been afforded privacy during the administration of all</p>	W 331			

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W 331 W 382	<p>Continued From page 7 medications.</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 12301</p> <p>Based on observation and interview, the facility failed to ensure that medications were supervised at all times during medication administration for six of the six clients residing the facility. (Clients #1, #2 #3, #4, #5 and #6)</p> <p>The finding includes:</p> <p>On 4/22/10, at 6:42 p.m., the medication closet was observed unlocked. The nurse left the kitchen area, where the medication closet was located, to administer medication to Client #5. The medication closet remained unlocked and unsupervised until 6:55 p.m. when the nurse returned to the medication closet.</p> <p>During the interview on 4/22/10, at 7:16 p.m., the nurse acknowledged that all medications should have been locked except when being prepared for administration.</p> <p>At the time of the survey, there was no evidence that each medication had been secured, except for when being prepared for administration.</p>	W 331 W 382	<p>W382</p> <p>This Standard will be met as evidenced by:</p> <p>The RN will complete corrective actions for the nurse who failed to secure the medication closet. The RN will continue to monitor medication administration on an ongoing basis, provide feedback and direction to staff and implement additional actions as needed.</p>	5-7-10 ongoing
W 436	<p>483.47 (g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair,</p>	W 436		

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W 436	<p>Continued From page 8</p> <p>and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, staff interview, and record review, the facility failed to ensure the maintenance of assisted devices as recommended by the interdisciplinary team, for one of three clients in the sample. [Client #1]</p> <p>The findings include:</p> <p>On 4/22/10, at 3:57 p.m., two direct care staff were observed unloading Client #1 from the van, into his wheelchair after he returned from the day program. Staff then wheeled the client into the facility. The client proceeded to propel himself in the wheelchair at a moderate pace, using his feet to move down the hallway. Observation of Client #1's wheelchair in his bedroom on 4/23/2010, at approximately 2:30 p.m., revealed bilateral Velcro strips on the seat of the wheelchair, to which nothing was attached. The wheelchair was further noted to have no seat cushion.</p> <p>Interview with staff on 4/22/10, at 4:22 p.m., revealed Client #1 was encouraged to, and should walk as much as possible during the day. Interview with the qualified mental retardation professional (QMRP) on 4/23/10 at 2:35 p.m. revealed the client's use of the wheelchair was only recommended for distance travel. On 4/23/10 at approximately 2:35 p.m., staff indicated</p>	W 436	<p>W436</p> <p>This Standard will be met as evidenced by:</p> <p>The wheelchair monitoring and adaptive equipment process is currently under review. The QMRP will consult with the Physical Therapist to secure additional evaluation and assessment to include conditions wheelchair should be used. Once the cushion has been received all staff will receive training on use, maintenance and reporting on status of the equipment.</p>	5-2-10 Ongoing	

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W 436	Continued From page 9 that the seat cushion had been removed from the client's wheel chair because it was in poor repair. Further interview with the QMRP on 4/23/10, at 2:40 p.m., revealed that the condition of wheelchairs was monitored ongoing and documented weekly. The QMRP confirmed that Client #1's wheelchair should have a seat cushion attached to the Velcro strips. According to the QMRP, the physical therapist (PT) had assessed the client's wheelchair and recommended replacement of the seat cushion. The QMRP indicated that the cushion had been ordered in 2/2010, however had not been received yet. At the time of the survey, there was no evidence that the facility had maintained Client #1's seat cushion in good repair to ensure its consistent availability to maintain his comfort when sitting in his wheelchair.	W 436		
W9999	FINAL OBSERVATIONS Surveyor: 12301 The following observation were made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent a potential non-compliant practice: Throughout the survey, railings were observed attached to poles approximately 18 inches tall, near the front of the parking lot at the at the side of the facility. Further observation of the area revealed other multiple poles which had no railings attached. Interview with the qualified mental retardation professional (QMRP) on 4/23/10, at approximately 2:30 p.m., revealed that railings	W9999	W9999 This area will be reviewed to determine if further actions are needed to prevent potential non-compliant practices. Prior to the survey process both DRS and Maintenance Coordinator discussed poles and railings and the potential hazards. There are areas in the driveway requiring railings to prevent damage to the building and landscaping. The railings will be replaced and consideration will be given to increasing the height of the poles to prevent future damage to the rails. Home Managers will monitor staff to ensure adherence to vehicle safety rules and take necessary actions whenever concerns arise.	4-23-10 4-23-10 ongoing error NS

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W9999	Continued From page 10 had previously been installed on the poles where there were missing. At the time of the survey, however, there was no evidence that a determination had been made regarding the poles which lacked railings.	W9999		
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Health Regulation Administration

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1 000	INITIAL COMMENTS Surveyor: 12301 A re-licensure survey was conducted from 4/22/2010 through 4/22/2010. A random sampling of three residents was selected from a residential population of six males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the resident and administrative records, including the incident reports.	1 000		
1 090	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: Surveyor: 12301 Based on observation and interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP were maintained in a safe, orderly, and attractive manner for six of the six residents. (Residents #1, #2, #3, #4, #5, and #6) The findings include: During the inspection of the environment on 4/23/2010, beginning at 1:45 p.m., the following concerns were identified: A. Exterior: 1. The gutter installed at the rear of the building	1 090	1090 3504.1 Housekeeping This Statute will be met as evidenced by: Items 1 thru 7 will be repaired and items replaced as needed. The Home Managers will conduct weekly home inspections and report all concerns to the maintenance department for follow-up.	5-17-10 ongoing

Health Regulation Administration

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

STATE FORM 6800 DBG711

DATE: 5/27/10

If continuation sheet 1 of 12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032		
(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
1090	Continued From page 1 (left side) was not tightly secured. Additionally, on the left side of the building, a section of the gutter was also not tightly secured. 2. The down spout installed at the left corner of the building was bent, near the ground. 3. The paved area in front door of the exterior storage room, located on the left side of the building, had numerous cracked areas. B. Interior: 1. There was an accumulation of dirt in the drain of the floor in the utility room. In the same room, the floor was heavily soiled. Several cracked floor tiles were also observed in the utility room. 2. In the bathroom located on the left side of the facility, the rod in the towel rack was missing, however, the supporting end units remained on the wall. 3. In the bathroom located on the right side of the facility, one of several screws was missing from grab bar in the shower. 4. A hole, approximately 5 inches in diameter, was observed on the side of the cabinet located underneath the kitchen sink. 5. Multiple cracks were observed on the bottom of the left kitchen sink. An area of thick, gray caulking was observed across the width of the sink. 6. The seat of the chair in Resident #2's bed room was heavily stained. 7. The left knob was missing from the fourth	1090		

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1090	Continued From page 2 drawer in Resident #4' s storage chest. The aforementioned observations were acknowledged by the qualified mental retardation professional (QMRP) and the primary registered nurse (RN), who accompanied the surveyor through the facility during the inspection of the environment.	1090		
1180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP 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: Surveyor: 12301 Based on observation, staff interview, and record review, the GHMRP failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services in accordance with the individual program plan (IPP) for one of the three residents in the sample. (Resident #1) The findings include: 1. The facility's QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) included a data collection system directly related to the outcome of the ambulation objective for Resident #1. On 4/22/10, at 10:40 a.m., Resident #1's instructor was observed rolling him in a wheelchair from where he ate his snack in the treatment room to the sitting area, which was located approximately 30 feet away. The	1180	1180 3508.1 Administrative Support This Statute will be met as evidenced by: 1. Reference response to W237.	5.21.10 ongoing

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I 180	<p>Continued From page 3</p> <p>instructor then asked the resident to stand up from his wheel chair and assisted him to ambulate approximately 15 feet to the couch. At that time, the resident sat down on the couch.</p> <p>Interview with the instructor during the aforementioned observation revealed that he encourages the resident to walk every day because he does not like to walk as much as " he use to walk. "</p> <p>On 4/22/10, at 3:57 p.m., two direct care staff were observed unloading Resident #1 from the van into his wheelchair when he returned at the group home from the day program. Staff then wheeled the resident into the facility. The resident proceeded to propel himself in the wheelchair, using his feet to move himself down the hallway at a moderate pace. At 4:40 p.m., the resident was observed wheeling himself away from the keyboard, and starting down the hallway again using his feet to propel himself. A staff followed him, and asked him if he wanted to walk. The staff then assisted the resident to stand up from his wheelchair, however, the resident turned back toward his wheelchair and was assisted to sit back down.</p> <p>Upon the Resident #1's return from the day program on 4/23/10, he was observed being assisted to walk into the facility from the van.</p> <p>Interview with staff on 4/22/10, at 4:17 p.m., revealed Resident #1 should walk as much as possible and that he has a training objective to walk daily. Interview with the QMRP on 4/23/10, at approximately 3:15 p.m., indicated that during the current ISP year, the resident's distance tolerated during ambulation had progressed from 50 to 150 feet daily.</p>	I 180		

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1180	Continued From page 4 Record review on 4/23/10, at 4:30 p.m., revealed Resident #1's individual plan plan (IPP) included a goal dated 6/06/09, "To improve ambulation endurance." The objective stated, "Given stand-by assistance, Mr. [Resident] will ambulate 150 feet, 3 days a week, for 6 consecutive months. The review of program data for 4/10 indicated that on each day documented, the resident ambulated 150 feet. The review of the skill acquisition revealed that the training instructions were: "Given standby assistance, Mr. [Resident] will ambulate 150 feet, 3 days a week, for 6 consecutive months." At the time of the survey, the record, however, failed to specify how staff would be able to determine when the resident had ambulated 150 feet. At the time of the survey, there was no evidence the training program was designed to provide specific information to provide accurate monitoring of the resident's progress in the training objective. 2. The facility's QMRP failed to coordinate and monitor services to ensure the timely replacement of Resident #1's wheelchair cushion. [Federal Deficiency Report - Citation W436]	1180		
1206	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.	1206		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032	
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W 237	Continued From page 5 consecutive months."	W 237		
W 331	<p>At the time of the survey, the record, however, failed to specify how staff would be able to determine when the client had ambulated 150 feet. At the time of the survey, there was no evidence the training program was designed to provide specific information to provide accurate monitoring of the client's progress in the training objective.</p> <p>483.460(c) NURSING SERVICES</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: Surveyor: 12301</p> <p>Based on observation, interview and the record review, the facility's nursing services failed to coordinate services for two of the six clients residing in the facility. (Clients #3 and #6)</p> <p>The findings include:</p> <p>1. [Cross refer to W120]. The facility's nursing services failed to coordinate services to ensure the timely receipt of medication labels corresponding to the physicians orders for Clients #3 and #6 as evidenced below.</p> <p>Medication administration observations on 4/22/10, at 7:16 p.m., and 7:28 p.m. respectively, revealed Client #3 and Client #6 received ear drops.</p> <p>The review of the physician's orders on 4/22/10, at approximately 7:55 p.m., revealed that the ear</p>	W 331	<p>W331</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Cross reference response to W120. 2. Cross reference W120. 	5.14.10 original

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2010
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W 331	<p>Continued From page 6</p> <p>drops had been administered as prescribed by the primary care physician. The review of the labels on the ear drops revealed, however, that they had not been changed to reflect the currently prescribed dosages and frequency of the ear drops, to correspond with the physician's orders.</p> <p>Interview with the nurse during the medication administration confirmed that the physician had changed the orders to reflect the amount and frequency of the ear drops which were received by Clients #3 and #6. Interview with the RN revealed that the policy was to send the new medication orders to the pharmacy, whenever a medication order changed. At the time of the survey, however, there was no evidence that the coordination/follow-up had been effective to ensure that the pharmacy provided eardrops labeled in accordance with the currently prescribed dosage and frequency of the medication.</p> <p>2. [Cross refer to W120] The facility failed to ensure that Client #3 and #6 were provided privacy during the administration of ear drops as evidenced below.</p> <p>On 4/22/10, between 7:16 p.m. and 7:28 p.m., the LPN nurse administered ear drops for Clients #3 and #6, while they were in the bedroom together.</p> <p>Interview with the RN on 4/22/10, at approximately 7:55 p.m., revealed Client #3 and #6 should have each been alone when their ear drops were administered by the nurse.</p> <p>At the time of the survey, there was no evidence the facility had ensure that each client had been afforded privacy during the administration of all</p>	W 331			

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1401	Continued From page 7	1401		
1401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review, the GHMRP failed to ensure professional services for two of the four residents in the sample. (Residents #3 and #6)</p> <p>The findings include</p> <p>1. The pharmacy failed to ensure that medication labels coincided with the current physician's orders Residents #3 and #6 as evidenced below:</p> <p>a. Observation of the administration of Resident #3's medications on April 22, 2010 at 7:16 p.m. revealed that he received generic Debrox, 10 drops in his left ear. Interview with the medication nurse, the licensed practical nurse (LPN) on 4/22/10 at 7:20 p.m., revealed that the ear drops were recommended by the ear nose and throat clinic on 4/15/2010 to soften the wax in Resident #3 ear. The review of the label on the ear drops on 4/22/10 at 7:50 p.m. revealed instructions to administer Resident #3 five (5) drops of the medication in each ear twice daily. According to the most recent physician's order, dated April 15, 2010 the resident was prescribed to receive "Debrox 10 drops daily in left ear x 14 days" for</p>	1401	<p>1401</p> <p>3520.3</p> <p>This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Reference response to W120. 2. Reference responses to W120 and 331. 3. Reference response to W382. 4. Reference response to W120. 	5.5.10 origing

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1401	<p>Continued From page 8</p> <p>ear wax removal.</p> <p>At the time of the survey, there was no evidence the pharmacy had ensured that the label on Resident #3's ear drops corresponded with the current physician's order.</p> <p>b. Observation of the administration of Resident #6's medications on April 22, 2010 at 7:20 p.m., revealed that he received generic ear drops, 2 drops in both ears.</p> <p>Interview with the medication nurse, the LPN on 4/22/10 at 7:24 p.m. revealed that the drops were prescribed by the primary care physician to the keep the wax in Resident #6's ears soft.</p> <p>The review of the label on the ear drops on 4/22/10 at 7:52 p.m. revealed instructions to administer Resident #6 five (5) drops of the medication in each ear twice daily for the first five days in the month. The physician's order dated 3/1/2010 included an order for "Debrox 6.5% drops: 2 drops in both ears, 2 times a week for cerumen impaction." The 4/2010 medication administration record also documented a physician's order dated 3/10/2010 for "Eardrops (generic debrox) 6.5 %, instill 2 drops in each ear 2 times a week for cerumen impaction. "</p> <p>At the time of the survey, however, there was no evidence the pharmacy had ensured that the label on Resident #6's ear drops corresponded with the current physician's medication order.</p> <p>2. The GHMRP's nursing services failed to coordinate services to ensure the timely receipt of medication labels corresponding to the physicians orders for Resident's #3 and #6 as evidenced</p>	1401		

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1401	<p>Continued From page 9</p> <p>below</p> <p>Medication administration observations on 4/22/10 at 7:16 p.m. and 7:28 p.m. respectively, revealed Resident #3 and Resident #6 received ear drops.</p> <p>The review of the physician's orders on 4/22/10 at approximately 7:55 p.m. revealed that the ear drops had been administered as prescribed by the primary care physician. The review of the labels on the ear drops revealed, however, revealed that they had not been changed to reflect the currently prescribed dosages and frequency of the ear drops, to correspond with the physician's orders.</p> <p>Interview with the nurse during the medication administration confirmed that the physician had changed the orders to reflect the amount and frequency of the ear drops which were received by Residents #3 and #6. Interview with the RN revealed that the policy was to send the new medication orders to the pharmacy, whenever a medication order changed. At the time of the survey, however, there was no evidence that the coordination/follow-up had been effective to ensure that the pharmacy provided eardrops labeled in accordance with the currently prescribed dosage and frequency of the medication.</p> <p>3. The GHMRP failed to ensure that medications were supervised at all time during medication administration for Residents #1, #2, #3, #4, #5 and #6 as evidenced below.</p> <p>On 4/22/10 at 6:42 p.m., the medication closet was observed unlocked. The nurse left kitchen area, where the medication closet was located, to administer medications to Resident #5. The</p>	1401		

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1401	Continued From page 10 medication closet remained unlocked and unsupervised until 6:55 p.m. when the nurse returned to the medication closet. During the interview on 4/22/10 at 7:16 p.m., the nurse acknowledged that all medications should have been locked except when being prepared for administration. At the time of the survey, there was no evidence that each medication had been secured, except for when being prepared for administration. 4. [Cross refer to W120]. The facility failed to ensure that Residents #3 and #6 were provided privacy during the administration of ear drops as evidenced below: On 4/22/10, between 7:16 p.m. and 7:28 p.m., the LPN nurse administered ear drops for Residents #3 and #6, while they were in the bedroom together. Interview with the RN on 4/22/10, at approximately 7:55 p.m. revealed Residents #3 and #6 should have each been alone when their ear drops were administered by the nurse. At the time of the survey, there was no evidence the facility had ensure that each client had been afforded privacy during the administration of all medications.	1401		
1999	FINAL OBSERVATIONS Surveyor: 12301 The following observation were made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent a	1999	1999 Final Observations Reference response to W9999	4-23-10 ongoing

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1999	Continued From page 11 potential non-compliant practice: Throughout the survey, railings were observed attached to poles approximately 18 inches tall, near the front of the parking lot at the at the side of the GHMRP. Further observation of the area revealed other multiple poles which had no railings attached. Interview with the qualified mental retardation professional on 4/23/10 at approximately 2:30 p.m. revealed that railings had previously been installed on the poles where there were missing. At the time of the survey, however, there was no evidence that a determination had been made regarding the poles which lacked railings.	1999		