

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

PRINTED: 07/23/2012  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G203 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  |   | (X3) DATE SURVEY COMPLETED<br><br>07/11/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>INDIVIDUAL DEVELOPMENT, INC |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8010 DIX STREET, NE<br>WASHINGTON, DC 20019                            |   |  |
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| W 000   | INITIAL COMMENTS<br><br>A recertification survey was conducted from July 9, 2012 through July 11, 2012. A sample of three clients was selected from a population of four men and one woman with varying degrees of intellectual disabilities. This survey was inflated utilizing the fundamental survey process.<br><br>The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff and one client's guardian, as well as a review of client and administrative records, including incident reports.<br><br>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.] | W 000  |   |   |  |
| W 159   | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the monitoring and coordination of each client's habilitation and active treatment needs, for one of the three clients in the sample. (Client #3)<br><br>The findings include:<br><br>1. On July 9, 2012, at 6:36 p.m., the licensed practical nurse coordinator (LPN1) was observed  | W 159  |   | <p><i>Received 8/3/12</i></p> <p>Department of Health<br/>Health Regulation &amp; Licensing Administration<br/>Intermediate Care Facilities Division<br/>899 North Capitol St., N.E.<br/>Washington, D.C. 20002</p> |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Stephen A. Jenkins - Director of Residential Services* TITLE \_\_\_\_\_ (X6) DATE *8/3/12*

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 159   | <p>Continued From page 1</p> <p>stirring 4 teaspoons of Thick 'n Easy powder into an 8 oz cup of water with lemon juice while preparing Client #3's medications. She stated that all liquids should be thickened to a "nectar consistency" to reduce the likelihood of aspiration.</p> <p>On July 10, 2012, at 7:20 a.m., Client #3, who is totally dependent on staff for feeding and other activities of daily living, was observed being fed breakfast by a direct support staff (S2) at the dining room table. Observation and interview with S2 revealed that the client's water had been thickened to a nectar consistency.</p> <p>On July 10, 2012, at 12:05 p.m., a direct support staff person (DP1) at Client #3's day program stirred Thick 'n Easy into 4 oz of water and stated that his liquids were to be "honey thick." At 12:37 p.m., DP1 presented the client's mealtime protocol (MP), dated October 17, 2011; it reflected "honey consistency" for liquids.</p> <p>On July 10, 2012, at 3:05 p.m., observation and interview with another direct support staff (S3) in the home revealed that Client #3's water had been thickened to a nectar consistency for his afternoon snack. S3 pointed to the client's MP on the dining table. Review of this MP, dated March 9, 2011, revealed "nectar consistency."</p> <p>Client #3's medical and habilitation records were reviewed in the home on July 10, 2012, beginning at 3:29 p.m., to determine why there were two differing MPs being implemented in the home and day program and to ascertain the current order for consistency of liquids. Whereas the MP dated March 9, 2011 reflected "nectar consistency," the</p> | W 159  | <p><b>W159 Qualified Mental Retardation Professional</b></p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> <li>Resident #3 received an updated mealtime protocol (MP) from the Speech and Language Pathologist on 7/12/12 to reflect a "nectar consistency" for his liquids. The QIDP delivered the updated MP to the day program and had day program staff to sign a receipt of this updated mp. This signed receipt will be kept in the individual's clinical record.</li> </ol> <p>The QIDP will adhere to policy as it relates to each individual's treatment program to be integrated, coordinated and monitored. The QIDP will ensure the coordination of exchange of information and monitoring between disciplines according to individuals assessed needs. Documentation to include signed receipts of delivered information and exchange of information will be kept in respective individuals' clinical record.</p> <p>The QIDP will coordinate with the SLP and other service providers for in-service training on mealtime protocols, liquid and food consistencies, etc. immediately following any changes.</p> | 8/5/12                                       |

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| W 159   | Continued From page 2<br><br>speech/language pathologist (S/LP) updated it, on July 21, 2011, to reflect "honey consistency." The S/PL, however, documented a mealtime observation on August 31, 2011, at which time staff reportedly implemented the MP correctly, including "nectar thickened" liquids. A December 16, 2011 revision to Client #3's MP also reflected "honey consistency." There was no evidence of a more recent MP. Annual and quarterly nutritional assessments from the previous 12 months all reflected "nectar" liquids. The current physician's order sheets (POS) dated June 1, 2012, reflected "nectar liquids."<br><br>On July 11, 2012, at 8:00 a.m., the facility's former QIDP (QIDP2, Nov. 2011 - June 2012) was unable to clarify the discrepancies in the mealtime protocols (MPs). At 10:45 a.m., the current QIDP (QIDP1) said she would review Client #3's records and seek clarification. The S/LP was interviewed in the facility on July 11, 2012, beginning at 12:38 p.m. While seated at a computer, she said she was updating Client #3's MP. She confirmed that the client's current order was for "nectar consistency." Further interview revealed that she recalled having changed the consistency to "honey" some time in 2011, after facility staff had said the client "did better" with honey consistency. At 1:10 p.m., however, review of Client #3's POS for the period March 1, 2011 - June 1, 2012 revealed the order for "nectar liquids" had remained unchanged throughout the 15-month period. QIDP1, who was present at the time of the interview, stated that she would bring the newly-updated MP to the day program and in-service their staff.<br><br>There was no evidence that the QIDPs | W 159  |   |

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| W 159  | <p>Continued From page 3</p> <p>coordinated the exchange of information between disciplines (S/P L, nutrition, primary care physician, nurses, day program) to ensure that Client #3 received liquids in accordance with assessed needs.</p> <p>2. The facility's QIDP services failed to ensure that Client #3 received a recommended wheelchair timely, as follows:</p> <p>Observation of Client #3 on July 9, 2012, at 6:17 p.m., revealed that the material along the front edge of the foot box on his wheelchair had numerous tears, totaling approximately 8-inches in length. On July 10, 2012, at approximately 7:45 a.m., two direct support staff (S1 and S2) stated that Client #3 was due to receive a new wheelchair (specific date not known to them at the time).</p> <p>On July 11, 2012, beginning at 10:27 a.m., review of Client #3's physical therapy (PT) and adaptive equipment records revealed the following:</p> <ul style="list-style-type: none"> <li>- On May 12, 2011, the PT recommended a "new custom seating system and wheelchair."</li> <li>- On September 7, 2011, the (former) qualified intellectual disabilities professional (QIDP) wrote that Client #3 needed a "new custom seating system and wheelchair...His current seating system forces his head and trunk into flexion. He maintains a posterior pelvic tilt."</li> <li>- On September 30, 2011, a PT progress note indicated the current wheelchair was safe for transportation, while awaiting a new wheelchair.</li> </ul> | W 159  | <p>2. Resident #3 did receive his new wheelchair on 7/23/12.</p> <p>The facility's QIDP will adhere to the facility's adaptive equipment policy, specifically as it relates to acquisition, tracking, and timeliness of recommended adaptive equipment. The QIDP will inform all necessary parties, including the Clinical Services Division of DDS, in a timely manner when encountering difficulties of acquiring recommended adaptive equipment. IDI has instituted a tracking form to identify and address adaptive equipment concerns.</p> | 7/23/12   |

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| W 159  | <p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- On October 13, 2011, the PT performed an annual assessment, in which he repeated the recommendation for Client #3 to receive new wheelchair seating.</li> <li>- On October 17, 2012, the interdisciplinary team met to review Client #3's annual Individual Support Plan (ISP). The ISP indicated a "yes," the wheelchair was functioning. The ISP summary did not reflect the ongoing PT recommendation for a new seating system.</li> <li>- On January 19, 2012, the PT 1st Quarterly Review note reflected that Client #3 was to receive "a new custom wheelchair and seating system."</li> <li>- On April 11, 2012, the PT "again submitted paperwork" for a new wheelchair.</li> <li>- On July 9, 2012, the QIDP submitted a 719A form for repair of the head rest on Client #3's current wheelchair.</li> </ul> <p>On July 11, 2012, at 11:18 a.m., QIDP2 presented a 719A form for a "new wheelchair" that was signed by the nurse practitioner on September 15, 2011. She indicated that these documents had just been received by fax from the facility's corporate office.</p> <p>On July 11, 2012, at 3:25 p.m., review of the facility's Adaptive Equipment Policy (July 2003) revealed that most tasks were assigned to the QIDP. Replacement of adaptive equipment was to occur "within 60 days from the date the need was determined..." Continued review of the policy revealed "When there are delays...the QIDP will</p> | W 159   |   |                      |   |

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**W 159** Continued From page 5  
notify the Clinical Services Division, DDA...The interim plan will also be documented. This written notice will be filed in the customer's records. A tracking on the status of the acquisition will be made and shared with the Clinical Services Division, DDA, by the QIDP."

**W 159**

Moments later, concurrent interview with the newly-hired QIDP and the residential director revealed that Client #3 had been measured for a new wheelchair in January or early February 2012. They acknowledged that the facility had not maintained a tracking system for monitoring the status of the wheelchair acquisition. They stated that the DDS service coordinator was aware of the delays in acquiring Client #3's new wheelchair and confirmed that there was no evidence that the Clinical Services Division had been notified of the delays.

This is a repeat deficiency. See Federal Deficiency Report dated July 8, 2011.

**W 209** 483.440(c)(2) INDIVIDUAL PROGRAM PLAN

Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.

This STANDARD is not met as evidenced by:  
Based on interviews and record review, it could not be determined whether clients' legal guardians participated in their annual Individual Support Plan (ISP) meeting, for one of the three clients in the sample. (Client #2)

The finding includes:

**W 209 (Individual Program Plan)**

8/15/12

**W 209**

This Statute will be met as evidenced by:

1. [483.440(cc)(2)]: The QIDP, RD, direct support staff, and all provider staff will encourage guardians to participate in the development and review of annual plans by most effective means to include email, postal mail, and/or telephone notifications. Staff will document when participation is unobtainable and filed in the individual's clinical record.

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| W 209  | <p>Continued From page 6</p> <p>During the entrance conference on July 9, 2012, at approximately 4:45 p.m., the qualified intellectual disabilities professional (QIDP) indicated that Client #2 had a court-appointed guardian to represent his health care interests and provide substituted consent. This was confirmed on July 11, 2012, at approximately 12:22 p.m., through review of Client #2's ISP, dated October 17, 2011. Review of the ISP meeting attendance sheet revealed several members of the client's interdisciplinary team (IDT) were present. However, there was no evidence that the client's guardian was present at the meeting. Similarly, the IDT had met on April 25, 2012 for a 6-month review. Review of the April 25, 2012 signature sheet revealed no evidence that the guardian had been present or otherwise participated. The most recent correspondence with the guardian observed in Client #2's record was dated March 30, 2011 (more than a year prior to the survey).</p> <p>On July 11, 2012, Client #2's guardian was interviewed by telephone beginning at 1:54 p.m. The guardian indicated that former qualified intellectual disabilities professionals (QIDP2 and QIDP3) did not provide timely or accurate notifications of meetings. She further stated there was inadequate communication from facility management, in general, although the recently-hired QIDP (QIDP1) had "been somewhat better."</p> <p>The facility's residential director (RD1), QIDP1 and a longtime employee who once served as assistant director of residential services (QIDP4), were interviewed together in the facility on July</p> | W 209  |   |   |

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| W 209  | Continued From page 7<br>11, 2012, beginning at 2:47 p.m. They reported that a calendar of scheduled ISP meetings and quarterly review meetings for all clients routinely was mailed to every IDT member, including guardians, in October of each year. They thought Client #2's guardian would have received the calendar approximately one year prior to his October 17, 2011 ISP meeting. They stated that the former QIDP (QIDP3) had been known to communicate via emails. However, they acknowledged that there were no copies of correspondence or other documentation available to verify that the facility had provided timely and appropriate communications with Client #2's guardian.<br><br>The facility failed to show evidence that participation by Client #2's guardian was unobtainable. | W 209   |  |                      |   |
| W 368  | <b>483.460(k)(1) DRUG ADMINISTRATION</b><br><br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and review of client records, the facility failed to ensure that clients' medications were administered in accordance with physician's orders, for one of the five clients residing in the facility. (Client #5)<br><br>The finding includes:<br><br>The evening medication administration was observed on July 9, 2012, beginning at 5:40 p.m. Client #5 received his medications and nutritional   | W 368   | <b>483.460(k)(1) (Drug Administration)</b><br><br>This Statute will be met as evidenced by:<br><br>1. The RN reported to the prescribing physician that Resident #5 was observed by the surveyor to receive Thera-Plus supplement two times (10ml) instead of just once (5ml), as prescribed by the PCP on 7/13/12. The PCP then informed the RN that this was okay for him to have the double dosage.<br><br>The RN will train the LPNs on the provider's policy on "Medication Administration and Documentation."<br>The RN and NP will periodically monitor and observe medication administration in this home. | 8/15/12              |   |

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| W 368  | <p>Continued From page 8</p> <p>supplements via G-tube, between 7:08 p.m. - 7:26 p.m. Thera-Plus liquid supplement, 5 ml, was one of five medications observed being administered by the medication nurse (LPN2).</p> <p>On July 10, 2012, at 4:20 p.m., review of Client #5's physician's order sheets for July 2012 revealed that he was prescribed the following: "Thera-Plus liquid 5 ml via peg tube every day for nutritional supplement." Concurrent review of the client's medication administration record (MAR) revealed that the time designated for administering the supplement was 6 a.m. Further review of the MAR revealed that another nurse had documented having administered Thera-Plus 5 ml on the morning of July 9, 2012.</p> <p>On July 10, 2012, at 4:40 p.m., the facility's licensed practical nurse coordinator (LPN1) and the registered nurse (RN1) examined Client #5's current MAR and confirmed that another nurse (LPN3) had documented administering the Thera-Plus at 6 a.m. on the same day that an evening dose was observed being administered.</p> <p>On July 9, 2012, Client #5 was administered Thera-Plus supplement two times (10 ml) instead of just once (5 ml), as ordered by the prescribing physician.</p> | W 368  |  |   |
| W 369  | <p><b>483.460(k)(2) DRUG ADMINISTRATION</b></p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation, interview and record</p>   | W 369  | <p><b>W 369 483.460(k)(1) (Drug Administration)</b></p> <p>This Statute will be met as evidenced by:</p> <p>1. The RN will re-train LPNs on the policy for drug administration to ensure compliance with the physician's order and reporting of any irregularities to the PCP.</p> | 8/15/12   |

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| W 369   | <p>Continued From page 9</p> <p>review, the facility failed to ensure that all drugs were administered without error, for one of the five clients residing in the facility. (Client #5)</p> <p>The finding includes:</p> <ul style="list-style-type: none"> <li>The evening medication administration was observed on July 9, 2012, beginning at 5:40 p.m. Client #5 received his medications and nutritional supplements via G-tube, between 7:08 p.m. - 7:26 p.m. Thera-Plus liquid supplement, 5 ml, was among the five medications administered by the medication nurse (LPN2).</li> <li>On July 10, 2012, at 4:20 p.m., review of Client #5's physician's order sheets dated June 1, 2012, revealed the following: "Thera-Plus liquid 5 ml via peg tube every day for nutritional supplement." Concurrent review of the client's medication administration record (MAR) revealed that the time designated for administering the supplement was 6 a.m.</li> <li>On July 10, 2012, at 4:40 p.m., the facility's licensed practical nurse coordinator (LPN1) and the registered nurse (RN1) confirmed that the designated time for administering Client #5's Thera-Plus was 6 a.m. They further indicated that the initials on the July MAR reflected those of nurses who administered the 6 a.m. medications.</li> </ul> | W 369  |   |
| W 436   | <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>   | W 436  |   |

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| W 436   | Continued From page 10<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that recommended assistive devices were furnished timely, for one of the five clients residing in the facility. (Client #3)<br><br>The findings include:<br><br>The facility failed to ensure that Client #3 received a recommended wheelchair timely, as follows:<br><br>Observation of Client #3 on July 9, 2012, at 6:17 p.m., revealed that the material along the front edge of the foot box on his wheelchair had numerous tears, totalling approximately 8-inches in length. On July 10, 2012, at approximately 7:45 a.m., two direct support staff (S1 and S2) stated that Client #3 was due to receive a new wheelchair (specific date not known to them at the time).<br><br>According to the review of Client #3's habilitation records on July 11, 2012, beginning at 10:27 a.m., the physical therapist (PT) recommended the client receive a "new custom seating system and wheelchair" on May 12, 2011. Continued review of the record revealed that a former qualified intellectual disabilities professional (QIDP2) submitted a 719A form for the new wheelchair on November 4, 2011.<br><br>On July 11, 2012, at 3:25 p.m., review of the facility's Adaptive Equipment Policy (July 2003) revealed that replacement of adaptive equipment | W 436  | W 436 483.470(g)(2) (Space and Equipment)<br><br>This Statute will be met as evidenced by:<br>The acquisition of the new wheelchair for Resident #3 took place on 7/25/12.<br><br>IDI staff will maintain a tracking system in the home for monitoring the status of wheelchair and other adaptive equipment acquisition. The DRS will re-train the RD and QDDP on the adaptive equipment policy and acquisition. | 8/15/12              |  |

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| W 436   | Continued From page 11<br>was to occur "within 60 days from the date the need was determined..." When interviewed moments later, the newly-hired QIDP (QIDP1) and the residential director (RD1) acknowledged that the facility had not maintained a tracking system for monitoring the status of the wheelchair acquisition.<br><br>This is a repeat deficiency. See Licensure Deficiency Report dated July 8, 2011. | W 436  |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0207</b>   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                             | (X3) DATE SURVEY COMPLETED<br><br><b>07/11/2012</b>  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDIVIDUAL DEVELOPMENT, INC</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6010 DIX STREET, NE<br/>WASHINGTON, DC 20010</b> |  |
| (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)  |
| I 000  | <p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from July 9, 2012 through July 11, 2012. A sample of three residents was selected from a population of four men and one woman with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with direct support staff, nursing and administrative staff and one client's guardian, as well as a review of resident and administrative records, including incident reports.</p> <p>(Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.)</p>   | I 000  |  |
| I 180  | <p><b>3508.1 ADMINISTRATIVE SUPPORT</b></p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>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 provide adequate administrative support to ensure effective monitoring and coordination of each resident's habilitation and active treatment needs, for one of the three residents in the sample. (Resident #3)</p> <p>The findings include:</p> <p>1. On July 9, 2012, at 6:36 p.m., the licensed practical nurse coordinator (LPN1) was observed stirring 4 teaspoons of Thick 'n Easy powder into</p> | I 180  | <p><b>I 180 3508.1 Administrative Support</b> 7/12/12</p> <p>1. Resident #3 received an updated mealtime protocol (MP) from the Speech and Language Pathologist on 7/12/12 to reflect a "nectar consistency" for his liquids. The QIDP delivered the updated MP to the day program and had day program staff to sign a receipt of this updated mp. This signed receipt will be kept in the individual's clinical record.</p> <p>The QIDP will adhere to policy as it relates to the coordination of exchange of information between disciplines according to individuals assessed needs. Documentation to include signed receipts of delivered information and exchange of information will be kept in respective individuals' clinical record.</p> <p>The QIDP will coordinate with the SLP and other service providers for in-service training on mealtime protocols, liquid and food consistencies, etc. immediately following any changes.</p> |

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*[Signature]*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Director of Residential Services*

TITLE *8/3/12*

(X5) DATE

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| 1180  | <p>Continued From page 1</p> <p>an 8 oz cup of water with lemon juice while preparing Resident #3's medications. She stated that all liquids should be thickened to a "nectar consistency" to reduce the likelihood of aspiration.</p> <p>On July 10, 2012, at 7:20 a.m., Resident #3, who is totally dependent on staff for feeding and other activities of daily living, was observed being fed breakfast by a direct support staff (S2) at the dining room table. Observation and interview with S2 revealed that the resident's water had been thickened to a nectar consistency.</p> <p>On July 10, 2012, at 12:05 p.m., a direct support staff person (DP1) at Resident #3's day program stirred Thick 'n Easy into 4 oz of water and stated that his liquids were to be "honey thick." At 12:37 p.m., DP1 presented the resident's mealtime protocol (MP), dated October 17, 2011; it reflected "honey consistency" for liquids.</p> <p>On July 10, 2012, at 3:05 p.m., observation and interview with another direct support staff (S3) in the home revealed that Resident #3's water had been thickened to a nectar consistency for his afternoon snack. S3 pointed to the resident's MP on the dining table. Review of this MP, dated March 9, 2011, revealed "nectar consistency."</p> <p>Resident #3's medical and habilitation records were reviewed in the home on July 10, 2012, beginning at 3:29 p.m., to determine why there were two differing MPs being implemented in the home and day program and to ascertain the current order for consistency of liquids. Whereas the MP dated March 9, 2011 reflected "nectar consistency," the speech/language pathologist (S/LP) updated it, on July 21, 2011, to reflect "honey consistency." The S/PL, however,</p> | 1180   |   |

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| I 180  | Continued From page 2<br><br>documented a mealtime observation on August 31, 2011, at which time staff reportedly implemented the MP correctly, including "nectar thickened" liquids. A December 16, 2011 revision to Resident #3's MP also reflected "honey consistency." There was no evidence of a more recent MP. Annual and quarterly nutritional assessments from the previous 12 months all reflected "nectar" liquids. The current physician's order sheets (POS) dated June 1, 2012, reflected "nectar liquids."<br><br>On July 11, 2012, at 8:00 a.m., the facility's former QIDP (QIDP2, Nov. 2011 - June 2012) was unable to clarify the discrepancies in the mealtime protocols (MPs). At 10:45 a.m., the current QIDP (QIDP1) said she would review Resident #3's records and seek clarification. The S/LP was interviewed in the facility on July 11, 2012, beginning at 12:38 p.m. While seated at a computer, she said she was updating Resident #3's MP. She confirmed that the resident's current order was for "nectar consistency." Further interview revealed that she recalled having changed the consistency to "honey" some time in 2011, after facility staff had said the resident "did better" with honey consistency. At 1:10 p.m., however, review of Resident #3's POS for the period March 1, 2011 - June 1, 2012 revealed the order for "nectar liquids" had remained unchanged throughout the 15-month period. QIDP1, who was present at the time of the interview, stated that she would bring the newly-updated MP to the day program and in-service their staff.<br><br>There was no evidence that the QIDPs coordinated the exchange of information between disciplines (S/P L, nutrition, primary care physician, nurses, day program) to ensure that | I 180   |   |                    |   |

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| I 180   | Continued From page 3<br><br>Resident #3 received liquids in accordance with assessed needs.<br><br>2. The facility's QIDP services failed to ensure that Resident #3 received a recommended wheelchair timely, as follows:<br><br>Observation of Resident #3 on July 9, 2012, at 6:17 p.m., revealed that the material along the front edge of the foot box on his wheelchair had numerous tears, totaling approximately 8-inches in length. On July 10, 2012, at approximately 7:45 a.m., two direct support staff (S1 and S2) stated that Resident #3 was due to receive a new wheelchair (specific date not known to them at the time).<br><br>On July 11, 2012, beginning at 10:27 a.m., review of Resident #3's physical therapy (PT) and adaptive equipment records revealed the following:<br><br>- On May 12, 2011, the PT recommended a "new custom seating system and wheelchair."<br><br>- On September 7, 2011, the (former) qualified intellectual disabilities professional (QIDP) wrote that Resident #3 needed a "new custom seating system and wheelchair...His current seating system forces his head and trunk into flexion. He maintains a posterior pelvic tilt."<br><br>- On September 30, 2011, a PT progress note indicated the current wheelchair was safe for transportation, while awaiting a new wheelchair.<br><br>- On October 13, 2011, the PT performed an annual assessment, in which he repeated the recommendation for Resident #3 to receive new wheelchair seating. | I 180  | 2. Resident #3 did receive his new wheelchair on 7/23/12.<br><br>The facility's QIDP will adhere to the facility's adaptive equipment policy, specifically as it relates to acquisition, tracking, and timeliness of adaptive equipment. The QIDP will inform all necessary parties, including the Clinical Services Division of DDS, in a timely manner when encountering difficulties of acquiring necessary adaptive equipment. |

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| I 180   | Continued From page 4<br><br>- On October 17, 2012, the interdisciplinary team met to review Resident #3's annual Individual Support Plan (ISP). The ISP indicated a "yes," the wheelchair was functioning. The ISP summary did not reflect the ongoing PT recommendation for a new seating system.<br><br>- On January 19, 2012, the PT 1st Quarterly Review note reflected that Resident #3 was to receive "a new custom wheelchair and seating system."<br><br>- On April 11, 2012, the PT "again submitted paperwork" for a new wheelchair.<br><br>- On July 9, 2012, the QIDP submitted a 719A form for repair of the head rest on Resident #3's current wheelchair.<br><br>On July 11, 2012, at 11:18 a.m., QIDP2 presented a 719A form for a "new wheelchair" that was signed by the nurse practitioner on September 15, 2011. She indicated that these documents had just been received by fax from the facility's corporate office.<br><br>On July 11, 2012, at 3:25 p.m., review of the facility's Adaptive Equipment Policy (July 2003) revealed that most tasks were assigned to the QIDP. Replacement of adaptive equipment was to occur "within 60 days from the date the need was determined..." Continued review of the policy revealed "When there are delays...the QIDP will notify the Clinical Services Division, DDA...The interim plan will also be documented. This written notice will be filed in the customer's records. A tracking on the status of the acquisition will be made and shared with the Clinical Services Division, DDA, by the QIDP." | I 180  |   |

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| I 180  | Continued From page 5<br><br>Moments later, concurrent interview with the newly-hired QIDP and the residential director revealed that Resident #3 had been measured for a new wheelchair in January or early February 2012. They acknowledged that the facility had not maintained a tracking system for monitoring the status of the wheelchair acquisition. They stated that the DDS service coordinator was aware of the delays in acquiring Resident #3's new wheelchair and confirmed that there was no evidence that the Clinical Services Division had been notified of the delays.<br><br>This is a repeat deficiency. See Licensure Deficiency Report dated July 8, 2011.  | I 180  |  |   |
| I 227  | <b>3510.5(d) STAFF TRAINING</b><br><br>Each training program shall include, but not be limited to, the following:<br><br>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to show evidence that all employees had received ongoing training in first aid, for four of the eleven direct support staff. (S3, S4, S5 and S6)<br><br>The findings include:<br><br>On July 9, 2012, during the entrance conference at 5:25 p.m., the qualified intellectual disabilities | I 227  | <b>I 227 3510.5(d) Staff Training</b><br><br>This Statute will be met as evidenced by:<br><br>1. Employees S3, S4, S5, and S6 have now either provided proof of certification to the provider or has taken the First Aid class by 7/25/12 to become certified.<br><br><u>The RD and QIDP will maintain a training calendar to ensure that all employees receive ongoing first aid training and that the training records are updated in a timely manner. IDI's Training Director will notify employees and Management staff at least a month in advance of the expiration date, that there training will expire. The RD for the home will notify the employee of the next available class.</u> | 7/25/12   |

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| I 227   | Continued From page 6<br><br>professional (QIDP1) agreed to make available for review the personnel records of all employees, include evidence of first aid training. On July 11, 2012, beginning at 8:08 a.m., review of the personnel records failed to show evidence that the following direct support staff had received current training in first aid:<br><br>Staff #3 - first aid expired June 2012<br><br>Staff #4 - first aid expired November 2010<br><br>Staff #5 - first aid expired April 2011<br><br>Staff #6 - first aid expired May 2012<br><br>On July 11, 2012, at 8:55 a.m., QIDP1 acknowledged that there was no evidence of current first aid training for the four aforementioned employees. She stated, however, that some staff were scheduled to receive first aid training on that date (July 11, 2012) and agreed to seek additional information.<br><br>At 3:40 p.m., review of a signature sheet documented that S3 and S5 had attended first aid training that day (July 11, 2012). She agreed to seek further information to ascertain whether the staff had successfully passed the course. She also acknowledged that there was no additional information available regarding the status of S4's and S6's training in first aid.<br><br>The GHPID failed to establish a system to ensure that all employees received ongoing first aid training. | I 227  |   |                    |  |
| I 271   | 3513.1(b) ADMINISTRATIVE RECORDS<br><br>Each GHMRP shall maintain for each authorized  | I 271  |   |                    |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDIVIDUAL DEVELOPMENT, INC</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6010 DIX STREET, NE<br/>WASHINGTON, DC 20019</b> |   |
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| I 271  | Continued From page 7<br><br>agency's inspection, at any time, the following administrative records:<br><br>(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the group home for persons with Intellectual disabilities (GHPID) failed to ensure that all the required administrative records were available for inspection, for one of the ten consultants providing services.<br><br>The finding includes:<br><br>On July 9, 2012, during the entrance conference at 5:25 p.m., the qualified intellectual disabilities professional (QIDP1) agreed to make available for review the personnel records of all employees, including licensed professional health consultants.<br><br>On July 11, 2012, beginning at 9:20 a.m., review of the personnel records for health care professionals revealed no evidence of a current administrative record for the consulting social worker. At 9:45 a.m., QIDP1 said she would follow-up with the agency's main office. No additional information was presented before the survey ended later that afternoon. | I 271  | I 271 3515.1(b) Administrative Records<br><br>This Statute will be met as evidenced by:<br><br>1. The Administrative Assistant will maintain an updated personnel record for all health care professionals to include the consulting social worker. Administrative staff will review the consultant records monthly. Administrative staff will contact consultants a month in advance to renew and submit documentation prior to their expiration.<br><br><span style="float: right; font-size: 1.5em;">8/1/12</span> |
| I 473  | 3522.4 MEDICATIONS<br><br>The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.<br><br>This Statute is not met as evidenced by:  | I 473  |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>HFD03-0207                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>07/11/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>INDIVIDUAL DEVELOPMENT, INC |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6010 DIX STREET, NE<br>WASHINGTON, DC 20019 |   |  |
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| I 473   | Continued From page 8<br><br>Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all irregularities involving residents' drug regimens were reported to the prescribing physician, for one of the five residents of the facility. (Resident #5)<br><br>The finding includes:<br><br>The evening medication administration was observed on July 9, 2012, beginning at 5:40 p.m. Resident #5 received his medications and nutritional supplements via G-tube, between 7:08 p.m. - 7:26 p.m. Thera-Plus liquid supplement, 5 ml, was one of five medications observed being administered by the medication nurse (LPN2).<br><br>On July 10, 2012, at 4:20 p.m., review of Resident #5's physician's order sheets for July 2012 revealed that he was prescribed the following: "Thera-Plus liquid 5 ml via peg tube every day for nutritional supplement." Concurrent review of the resident's medication administration record (MAR) revealed that the time designated for administering the supplement was 8 a.m. Further review of the MAR revealed that another nurse had documented having administered Thera-Plus 5 ml on the morning of July 9, 2012.<br><br>On July 10, 2012, at 4:40 p.m., the facility's licensed practical nurse coordinator (LPN1) and the registered nurse (RN1) examined Resident #5's current MAR and confirmed that another nurse (LPN3) had documented administering the Thera-Plus at 8 a.m. on the same day that an evening dose was also observed being administered.<br><br>When interviewed again on July 11, 2012, at 1:38 | I 473  | I 473 3522.4 Medications<br><br>This Statute will be met as evidenced by:<br><br>1. The RN reported to the prescribing physician of the irregularity involving Resident #5's drug regiment on 7/13/12.<br><br>The RN will train the LPNs on the provider policies related to drug administration and reporting of drug regiment irregularities involving residents. | 8/15/12                                      |

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| I 473   | Continued From page 9<br><br>p.m., LPN1 and RN1 stated that to date, the facility had not reported the irregularly to Resident #5's prescribing physician.   | I 473  |   |
| I 500   | 3523.1 RESIDENT'S RIGHTS<br><br>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Based on observations, interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for two of the three residents in the sample. (Residents #2 and #3)<br><br>The findings include:<br><br>1. [483.440(c)(2)] The GHPID failed to ensure the participation of Resident #2's guardian in the development and review of his annual plan, as follows:<br><br>During the entrance conference on July 9, 2012, at approximately 4:45 p.m., the qualified intellectual disabilities professional (QIDP1) indicated that Resident #2 had a court-appointed guardian to represent his health care interests and provide substituted consent. This was confirmed on July 11, 2012, at approximately | I 500  | I 500 3523.1 Resident's Rights<br><br>This Statute will be met as evidenced by:<br><br>1. [483.440(cc)(2)]: The QIDP, RD, direct support staff, and all provider staff will ensure to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code and federal regulations 42 CFR 483 Sub-Part I for Resident #2 in the sample and all residents by encouraging guardians to participate in the development and review of annual plans by most effective means to include email, postal mail, and/or telephone notifications. Staff will document when participation is unobtainable and filed in the individual's clinical record.<br><br>8/13/12 |

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| I 500  | Continued From page 10<br><br>12:22 p.m., through review of Resident #2's ISP, dated October 17, 2011. Review of the ISP meeting attendance sheet revealed several members of the resident's interdisciplinary team (IDT) were present. However, there was no evidence that the resident's guardian was present at the meeting. Similarly, the IDT had met on April 25, 2012 for a 6-month review. Review of the April 25, 2012 signature sheet revealed no evidence that the guardian had been present or otherwise participated. The most recent correspondence with the guardian observed in Resident #2's record was dated March 30, 2011 (more than a year prior to the survey).<br><br>On July 11, 2012, Resident #2's guardian was interviewed by telephone beginning at 1:54 p.m. The guardian indicated that former qualified intellectual disabilities professionals (QIDP2 and QIDP3) did not provide timely or accurate notifications of meetings. She further stated there was inadequate communication from facility management, in general, although QIDP1 had "been somewhat better."<br><br>The facility's residential director (RD1), QIDP1 and a longtime employee who once served as assistant director of residential services (QIDP4), were interviewed together in the facility on July 11, 2012, beginning at 2:47 p.m. They reported that a calendar of scheduled ISP meetings and quarterly review meetings for all residents routinely was mailed to every IDT member, including guardians, in October of each year. They thought Resident #2's guardian would have received the calendar approximately one year prior to his October 17, 2011 ISP meeting. They stated that QIDP3 had been known to communicate via emails. However, they acknowledged that there were no copies of | I 500  |   |                    |   |

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| I 500   | Continued From page 11<br><br>correspondence or other documentation available to verify that the facility had provided timely and appropriate communications with Resident #2's guardian.<br><br>The facility failed to show evidence that participation by Resident #2's guardian was unobtainable.<br><br>2. [483.470(g)(2)] The GHPID failed to furnish and maintain Resident #3's recommended adaptive equipment, as follows:<br><br>Observation of Resident #3 on July 9, 2012, at 6:17 p.m., revealed that the material along the front edge of the foot box on his wheelchair had numerous tears, totaling approximately 8-inches in length. On July 10, 2012, at approximately 7:45 a.m., two direct support staff (S1 and S2) stated that Resident #3 was due to receive a new wheelchair (specific date not known to them at the time).<br><br>According to the review of Resident #3's habilitation records on July 11, 2012, beginning at 10:27 a.m., the physical therapist (PT) recommended the resident receive a "new custom seating system and wheelchair" on May 12, 2011. Continued review of the record revealed that a former qualified intellectual disabilities professional (QIDP2) submitted a 719A form for the new wheelchair on November 4, 2011.<br><br>On July 11, 2012, at 3:25 p.m., review of the facility's Adaptive Equipment Policy (July 2003) revealed that replacement of adaptive equipment was to occur "within 60 days from the date the need was determined..." When interviewed moments later, the newly-hired QIDP (QIDP1) | I 500  | 2. The acquisition of the new wheelchair for Resident #3 took place on 7/25/12.<br><br>IDI staff will maintain a tracking system in the home for monitoring the status of wheelchair and other adaptive equipment acquisition.<br><br>The DRS will re-train the RD and QDDP on the adaptive equipment policy and acquisition. |                    |  |

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| I 500  | Continued From page 12<br><br>and the residential director (RD1) acknowledged that the facility had not maintained a tracking system for monitoring the status of the wheelchair acquisition. [Also see I180.2]<br><br>This is a repeat deficiency. See Licensure Deficiency Report dated July 8, 2011. | I 500   |   |                    |   |