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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G122	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	3020 STANTON ROAD, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS A recertification survey was conducted from July 26, 2011 through July 28, 2011. A sample of three clients was selected from a population of six women with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff and clients in the home and at three day program, as well as a review of client and administrative records, including incident reports.	W 000	Received 9/18/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients included in the sample. (Client #2) The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2	W 124	W124 This Standard will be met as evidenced by: Individual #2's mother is her surrogate healthcare decision maker. The facility nurse and the QDDP has receive a refresher training on the process of inform consent and the condition that warranted inform consent to be used. A system has been put in place to ensure that QDDP is inform two weeks prior to medical appointment that sedation is required so that she can facilitate surrogate healthcare decision maker's review, approval of sedation prior to been administered to individual #2. In future, QMRP will ensure that legal guardians and surrogate healthcare decision maker for individuals are fully informed of all medications; QDDP will ensure that all parties are fully knowledgeable of the risk and benefit of each medication prescribed for the individual. QDDP will also ensure documentation of information regarding all efforts to involve legal guardian and surrogate decision makers in the decision-making process are documented and on file in the individual records	8/31/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director of Residential Services	8/26/11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 124	Continued From page 1	W 124		

and/or her legal guardian for sedations given for medical appointments, as evidenced below:

During the entrance conference on July 26, 2011, at 8:20 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that Client #2's mother operated as the client's designated surrogate healthcare decision-maker due to the client's inability to give informed consent for the use of her medications.

On July 26, 2011, at 8:20 p.m., Client #2 was observed to be administered Fluoxetine HCl 20 mg capsule by the medication nurse. During this time, the nurse revealed that the client was prescribed this medication to manage her mood disorder. The nurse also revealed that the client required sedation for medical appointments due to her repeated failure to cooperate with the clinicians.

On July 27, 2011, at 11:00 a.m., review of Client #1's psychological assessment dated May 11, 2011, confirmed that the client lacked the capacity to grant, refuse, or withdraw consent to any ongoing medical treatment.

On July 27, 2011, at 4:24 p.m., review of Client #2's physician orders dated November 1, 2010 through June 1, 2011, revealed a standing order for "Ativan 2 tabs (4 mg) by mouth prior to appointments.

Review of the medication administration records on July 27, 2011, at 5:17 p.m., confirmed that Client #2 received Ativan (4 mg) by mouth for medical appointments on the following dates:

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W 124	Continued From page 2 November 2, 2010 November 9, 2010 April 6, 2011 April 18, 2011 May 20, 2011 May 24, 2011 May 31, 2011 July 11, 2011 Interview with the Registered Nurse and the QIDP on July 28, 2011, at 10:06 a.m., revealed consent was not obtained from Client #2's mother for the aforementioned appointments. Further interview revealed the client is non-compliant, therefore a standing order for sedation was put in place instead of obtaining consent from the client's mother. At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs, including the benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to her legally authorized representative for the use of the aforementioned sedation.	W 124		
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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) integrated, coordinated, and monitored	W 159	**W159(1,2, and 3)** **This Standard will be met as evidenced by:** The QDDP will receive additional training on timely coordination of services for individuals served, QDDP will receive additional in-service training on program implementation and following up with programs as formulated by the IDT. QDDP will receive a refresher training on the established Adaptive Equipment Protocol. QDDP will ensure that all services recommended for individuals are provided and on timely manner. DRS will provide a routine audit of individual record to ensure compliance with this standard as set forth.	9/13/11

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W 159	Continued From page 3 active treatment programs for three of three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. The facility's QIDP failed to coordinate services to ensure drugs used to control inappropriate behavior were used only as an integral part of the client's individual program plan for Clients #1 and #2. (See W312) 2. The facility's QIDP failed to coordinate services to ensure Client #2 received continuous active treatment. (See W249) 3. The facility's QIDP failed to coordinate services to ensure that chest harnesses worn by Clients #1 and #3 were approved by the human rights committee. (See W262.2)	W 159		
W 249	483.440(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 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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified intellectual professional professional (QIDP) failed to ensure	W 249		

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W 249	Continued From page 4 clients received continuous active treatment, for one of the three clients included in the sample. (Client #2) The finding includes: On July 26, 2011, beginning at 11:56 a.m., Client #2 was observed at her day program with her residential one to one staff. At 11:58 a.m., the one to one staff walked Client #2 to the bathroom. One minute later, Client #2 followed the one to one staff to the cafeteria. At 12:02 p.m., the one to one staff opened the client's lunch and placed it in front of her. While the client was eating, the one to one staff verbally asked the client to drink her juice. After the client completed her lunch at 12:11 p.m., the one to one staff pointed to the sink, the client then walked into the kitchen and placed her plate and cup inside the sink. Further observation on July 26, 2011, at 3:33 p.m., revealed Client #2 arrived home from the day program with her one to one staff. At 4:15 p.m., the one to one staff stated, "I know she has to go to the bathroom." The one to one staff was observed to motion and tell Client #2 to come on. The client then followed the staff member to the bathroom. At 4:49 p.m., the one to one staff stated, I'm going to get her a glass of water because she will not tell me that she wants something to drink. The client then followed the one to one staff into the kitchen to drink her water. Interview with the one to one staff on July 26, 2011, at 4:25 p.m., revealed she was not her "normal " one to one staff.	W 249	W249(#'s 1 and 2) **This Standard will be met as evidenced by:** Review of training record file showed that staff in the home were trained on Universal sign language on 6/10/11. Speech Language Pathologist completed training on Individual #2 programs on August 3, 2011. QDDP will coordinate a refresher sign language training for all staff with Director of Training. In the future, QDDP will periodically conduct a routine monitoring of individual #2 program implementation to ensure compliance with this standard as set forth.	8/3/11

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W 249	Continued From page 5	W 249		

Review of Client #2's individual program plan (IPP) dated June 1, 2011 on July 27, 2011, at 9:15 a.m., revealed the following objectives for the client's home and day program:

(Day Program Objectives)
Given verbal prompts, [the client] will use American Sign Language for "eat" to communicate her need to eat;

Given verbal prompts, [the client] will use American Sign Language for "toilet" to communicate her need to use the bathroom;

(Facility Objective)
[The Client] will use six basic manual signs (eat, drink, toilet, more, sick and hurt) Monday through Friday with one additional manual sign included each quarter

At no time during the survey did the one to one staff use basic sign language to communicate with the client, nor did the staff member encourage the use of sign language.

During a face to face interview on July 27, 2011, at 3:00 p.m., the Speech Pathologist verified that Client #2 had a basic hand signing program related to activities of daily living. Further interview revealed she will conduct training before August 1, 2011.

Interview with the one to one staff on July 28, 2011, at 10:52 p.m., revealed she did not use sign language with Client #2. Continued interview revealed she attended a sign language class in June 2011.

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W 249	Continued From page 6 There was no evidence that the facility implemented Client #2's communication training program as recommended in the IPP.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: ++Based on observation, interview and record review, the facility failed to ensure that restrictive measures had been reviewed and approved by the Human Rights Committee (HRC), for three of three clients included in the sample. (Clients #1, #2, and #3) The finding includes: 1. [Cross Reference - W124] Review of the HRC minutes on July 28, 2011, at 11:14 a.m., failed to provide evidence that the use of sedation was reviewed and approved by the HRC prior to its administration to Client #2. Interview with the qualified intellectual disabilities professional (QIDP) on the same day, at approximately 11:30 a.m., confirmed that the HRC had not approved the use of sedation for the client. 2. The facility failed to ensure approval from the HRC for the use of chest harnesses for Clients #1 and #3.	W 262	8/31/11 **W262** **This Standard will be met as evidenced by:** **Reference response to W124** QDDP will discuss/review all information pertaining to various treatments, adaptive equipments, including medication for sedation with the Human Rights Committee. In addition, the QDDP will discuss the risk and benefits of each adaptive equipment/medication ordered and ensure approval/consent from the individual legal guardian and family members. Evidence of such meeting will be filed inside the individual file.	

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W 262	Continued From page 7 On July 26, 2011, at 8:30 a.m., Clients #1 and #3 were observed seated in their wheelchair and secured by chest harnesses. Interview with the QIDP on July 28, 2011, at 11:40 a.m. ,revealed the facility's HRC had reviewed and approved the wearing of chest harnesses by Clients #1 and #3. Review of the HRC minutes on July 28, 2011, at 11:44 a.m., revealed that the client's wearing of chest harnesses was presented to the HRC for review and approval on June 29, 2011. The minutes revealed that the HRC requested more information concerning the harnesses, however, not approve their use for the clients on that date. At the time of the survey, there was no evidence that the HRC had approved the wearing of the chest harnesses by Clients #1 and #3.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of three clients included in the sample. (Client #2)	W 263	W263 This Standard will be met as evidenced by: Reference response to W124	8/31/11

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W 263	Continued From page 8 The finding includes: [Cross refer to W124.] The facility failed to ensure that written informed consent was obtained prior to the administration of sedation for Client #2.	W 263		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure drugs used to control inappropriate behavior were used only as an integral part of the client's individual program plan for two of the three clients in the sample. (Clients #1 and #2) The finding includes: 1. The facility failed to ensure that the individual program plan identified sedation usage as an intervention to address Client #2's non-compliance during medical appointments. [Cross refer to W124]. On July 27, 2011, at 11:50 a.m., interview with the facility's qualified intellectual disabilities professional (QIDP) revealed Client #2 had a behavior support plan (BSP) to address targeted behaviors, which included non-compliance. Further discussion with the QIDP revealed that the client's	W 312	W312 (#'s 1 and 2) 8/12/11 This Standard will be met as evidenced by: Reference response to W124 Psychologist completed a desensitization program for individual #2 on 8/4/11 and staff were trained on 8/12/11. QDDP is following up with psychologist to ensure desensitization program is developed for individual and any other individual that require sedation for routine medical appointments. In the future each plan will be presented to HRC for consent/approval prior to its usage.	

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W 312	Continued From page 9	W 312		

non-compliance during medical appointments had been an ongoing problem since she was admitted to the facility in 2008. The QIDP indicated that a training objective designed to reduce the the client's non-compliant behavior during health care appointments, which was implemented during the previous individual support plan (ISP) year was discontinued after the client failed to progress. Interview with the registered nurse (RN), however, revealed that the client had an ongoing physician's order for Ativan 4 mg to improve her compliance during all of her health care appointments.

On July 27, 2011, at 4:24 p.m., review of Client #2's physician orders dated November 1, 2010 through June 1, 2011, revealed a standing order for "Ativan 2 tabs (4 mg) by mouth prior to appointments. The physician's order dated June 1, 2011 physician's order (original date: March 26, 2010) also stated: Encourage client to be compliant with medical appointments.

Review of the medication administration records on July 27, 2011, at 5:17 p.m., confirmed that Client #2 received Ativan (4 mg) by mouth for seven medical appointments between November 2, 2010 and July 2011. At the time of the survey, however, there was no evidence of a program that addressed the client's non-compliant behaviors at medical appointments, to justify the use of the sedation.

2. [Cross refer to W331] The facility failed to ensure that the individual program plan (IPP) identified sedation usage as an intervention to address Client #1's non-compliance during medical appointments.

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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: Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs of one of three clients in the sample (Client #1) The findings include: 1. Interview with the facility's qualified intellectual disabilities professional (QIDP) on July 28, 2011, at 1:25 p.m. revealed Client #1 sometimes required sedation to improve her compliance during medical appointments. The QIDP's statement was acknowledged by the registered nurse (RN). Record review on July 28, 2011, at 1:35 p.m., revealed a standing order dated May 10, 2011, for Lorazepam (Ativan) 2 mg tablet , 1 tab by mouth prior to appointments. On July 28, 2011, at 2:15 p.m., review of a nursing progress note dated June 1, 2011 (12:00 a.m. - 8:00 a.m.), revealed that Client #1 was sedated for a 10:00 a.m. gynecological (Gyn) appointment. The review of the medication administration record (MAR) revealed that on June 1, 2011, Client #1 was given Lorazepam (Ativan) 2 mg at 7:30 a.m. According to a nursing progress note dated May 26, 2011, however, the clinic rescheduled the appointment from June 1, 2011 to July 6, 2011. A GYN - Pap Smear	W 331	W331 (#'s 1 and 2) **This Standard will be met as evidenced by:** **Reference response to W312** QDDP will follow up with the psychologist to coordinate training with the nursing staff with regards to sedation with medical appointments and desensitization programs. RN will continue on-going training and monitoring of protocols/practices to ensure compliance as set forth.	8/12/11

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W 331	Continued From page 11 consultation report dated July 6, 2011, stated "Please follow-up in six weeks for complete evaluation soon after sedation." At the time of the survey there was no evidence services were coordinated to prevent the client's sedation on June 1, 2011 2. [Cross refer to W368] The facility's nursing services failed to ensure that medication was administered in compliance with the physician's orders for Client #1.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to ensure that all drugs were administered in compliance with the physician orders for one of the three clients in the sample. (Client #1) The findings include: Interview with the facility's qualified intellectual disabilities professional (QIDP) on July 28, 2011, at 1:25 p.m., revealed Client #1 sometimes required sedation to improve her compliance during medical appointments. The QIDP's statement was acknowledged by the registered nurse (RN). Record review on July 28, 2011, at 1:35 p.m., revealed a standing order dated May 10, 2011 for Lorazepam (Ativan) 2 mg tablet , 1 tab by mouth	W 368	W368 This Standard will be met as evidenced by: Facility RN will provide additional training to nurses on timely documentation of medication administered to individuals as ordered by physician. The RN will ensure that a consistent and accurate system is established that ensures that all medication prescribed by the physician were given in accordance with establish standard	9/13/11

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	09G122	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 368	Continued From page 12 prior to appointments. A physician's order dated May 16, 2011, revealed Ativan 2 mg was prescribed for an EEG Test. The LPN's and the surveyor's review or the EEG consultation report dated May 16, 2011, as well as the medication administration record (MAR) and nursing progress notes, revealed they failed to document that the client was administered the sedation prior to the May 16, 2011 appointment, as prescribed by the physician.	W 368	**W436** **This standard will be met as evidenced by:** #1. Adaptive equipment vendor indicated that armrest has been ordered for individual #4. QDDP and RD will continue to follow up with IDI adaptive equipment coordinator to ensure timely repair of individual #4's armrest. All correspondence will be documented according to the adaptive equipment protocol. #2: QDDP will follow up with DDS service coordinator to request for support in obtaining individual #6's wheelchair. In addition, IDI adaptive equipment coordinator will follow up with vendor to request for updated status on individual #6 new wheelchair. All correspondence will be documented according to the adaptive equipment protocol. As previously mentioned, the QDDP will be trained from the DRS on process of adaptive equipment to ensure clear understanding of steps to be taken when equipment request is delayed.	8/31/11
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility failed to ensure adaptive equipment and devices identified by the interdisciplinary team as needed by the clients, was maintained in good repair for two of six clients residing in the facility. (Clients #4, and #6). 1. The facility failed to ensure that Client #4's wheelchair was maintained in good repair, as evidenced below: On July 27, 2011, at 9:15 a.m., observation of Client #4 revealed she had severe bilateral contractures of her elbows, causing her hands to be pointed upward. Observation of her wheelchair revealed the left arm pad was missing, leaving	W 436		

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only the metal part to support the client's elbow.

On July 27, 2011, at approximately 12:50 p.m., the discussion with the residential director (RD) revealed the screws required to secure the pad to the left armrest had recently become detached from the chair, however the exact date was unknown. The RD indicated that the adaptive equipment technician had been requested to come to the facility during the survey to put the armrest back on the client's wheelchair. On July 28, 2011, at 2:20 p.m., the RD and the qualified intellectual disabilities professional (QIDP) reported that the client was not home when the adaptive equipment technician arrived to perform the repair to the wheelchair.

On July 28, 2011, at 2:25 p.m., the review of the records provided failed to determine how long the armrest had been missing from Client #4's wheelchair. At the time of the survey, there was no evidence the client's wheelchair was maintained in good repair.

2. The facility failed to ensure that Client #6's wheelchair was maintained in good repair.

Observation of Client #6's custom molded wheelchair on July 26, 2011, at 7:03 p.m., revealed torn areas (seat and back) on the chair, which were partially covered with tape. The right armrest was observed to be lower than the left armrest, and was slightly loose.

Interview with the RD on July 27, 2011, at 12:50 p.m. revealed the tape had been applied as a temporary measure to cover the torn areas on the vinyl upholstery of Client #6's wheelchair. The

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RD indicated that the armrests appeared to be in their usual position. Continued discussion with the QIDP on July 28, 2011, revealed that the facility had applied for a new wheelchair for the client "over a year ago." According to the QIDP, during the interim period, various repairs had been made to the client's wheelchair to ensure that it remained functional. The QIDP further indicated that she continued to follow-up on the client's new wheelchair, however, the wheelchair vendor went out of business, which proved to be a major setback.

On July 28, 2011, at 11:50 a.m., record review revealed the following information concerning Client #6's wheelchair:

a. Seating and Mobility Evaluation," dated August 11, 2009. The physical therapist (PT) documented that the client will benefit from a new custom molded wheelchair."

b. QIDP progress note dated December 30, 2009, revealed the PT conducted the final measurement for the client's new wheelchair on December 30, 2009. The QIDP further noted that the wheelchair vendor stated that the delivery date for the wheelchair was approximately January 30, 2010.

c. July 1, 2010 - e-mail sent to PT requesting to complete the measurements for client's new wheelchair.

d. July 20, 2010 - QIDP telephoned the wheelchair vendor and was informed that the vendor had not received any of the required paperwork for the client's chair. The PT was

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telephoned to update him on the matter.

e. August 10, 2010 - Repairs were made to the client's chair by a different vendor.

f. September 17, 2010 - An attempt to reach wheelchair company to discuss the status of the new wheelchair was unsuccessful; a message was left.

g. October 11, 2010 - The medical director and adaptive equipment coordinator were notified that the wheelchair vendor had not responded to the inquiry concerning the status of the client's new wheelchair. The medical director indicated that a new wheelchair vendor would be sent to the home.

Although the progress notes documented various repairs to the Client #6's chair between October 11, 2010 and March 2011, there was no further mentioning of the efforts to obtained the client's wheelchair until March 2011, five months later.

h. March 4, 2011 - New 719 forwarded for the client's new wheelchair. The PT was telephoned for an updated progress report for the client to receive a new wheelchair.

i. March 28, 2011 - Adaptive Equipment Monitoring Report (AEMR) "Needs new custom molded wheelchair. Approved; must be molded/request made to PT for date and time.

j. May 3, 2011 - Wheelchair vendor was e-mailed to request an updated on the client's new wheelchair.

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W 436	Continued From page 16 At the time of the survey, there was no evidence that Client #6's current wheelchair was maintained in good repair, and that timely measures were implemented to facilitate timely procurement of the recommended new wheelchair.	W 436		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received their meals in the form and consistency as prescribed, for one of the three clients in the sample. (Client #2) The finding includes: Observation on July 26, 2011, at 12:02 p.m., revealed the one to one staff served Client #2 an uncut toasted turkey, roast beef, and cheese sandwich. As the client ate the sandwich, the one to one staff instructed the client to put her sandwich on her plate and drink her juice. The client then ate her fruit cup without assistance. At 12:09 p.m., the one to one staff opened Client #2's Fig Newton cookie. The one to one staff then broke the cookie into small pieces and gave the client one piece at a time to eat. The client was observed to tolerate her food well as offered. Interview with the one to one staff on the same day, at 12:30 p.m., revealed Client #2 is on a 1200 calorie diet. Further interview revealed she broke and handed the client her cookies one at a	W 474	W474 **This Standard will be met as evidenced by:** A refresher training was provided to staff on individual #2 mealtime protocol and meal texture. QDDP is expected conduct mealtime observation to ensure staff follow protocol as outlined. The QDDP will coordinate with Speech Pathologist for announced and unannounced mealtime observations.	8/15/11

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time because she eats too fast.

Review of Client #2's physician order dated June 1, 2011, on July 26, 2011, at 4:14 p.m., revealed the client was prescribed a chopped diet. Review of the mealtime protocol at 4:40 p.m., revealed an order to "hand cut " the client's meal into bite-size pieces. However, stringy vegetables should be finely chopped.

A face to face interview with the Speech Pathologist on July 27, 2011, at 3:05 p.m., confirmed Client #2 was prescribed a chopped textured diet Further interview revealed the client puts too much food in her mouth; therefore, the one to one staff was required to hand cut the client's sandwich into bite size pieces. The Speech Pathologist also indicated that she will retrain the staff again August 1, 2011.

The facility failed to ensure Client #2 received her food in the texture prescribed to meet her developmental needs.

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I 000	INITIAL COMMENTS A licensure survey was conducted from July 26, 2011 through July 28, 2011. A random sampling of three residents was selected from a residential population of six females with various levels of intellectual and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows. (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... 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 ensure that modified diets were planned, prepared, and served by individuals who have received instructions from a dietitian for one of three residents in the sample. (Resident #2) The finding includes: The QIDP failed to ensure each staff was effectively trained to implement Resident #2's mealtime protocol, as evidenced below:. Observation on July 26, 2011, at 12:02 p.m., revealed the one to one staff served Resident #2 an uncut toasted turkey, roast beef, and cheese sandwich. As the resident ate the sandwich, the one to one staff instructed the resident to put her sandwich on her plate and drink her juice. The	I 042	**3502.2b:** **This Statute will be met as evidenced by:** A refresher training was provided to staff on individual #2 mealtime protocol and meal texture. QDDP is expected conduct mealtime observation to ensure staff follow protocol as outlined. The QDDP will coordinate with Speech Pathologist for announced and unannounced mealtime observations.	8/15/11

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I 042	Continued From page 1 resident then ate her fruit cup without assistance. At 12:09 p.m., the one to one staff opened Resident #2's Fig Newton cookie. The one to one staff then broke the cookie into small pieces and gave the resident one piece at a time to eat. The resident was observed to tolerate her food well as offered. Interview with the one to one staff on the same day, at 12:30 p.m., revealed Resident #2 is on a 1200 calorie diet. Further interview revealed she broke and handed the resident her cookies one at a time because she eats too fast. Review of Resident #2's physician order dated June 1, 2011, on July 26, 2011, at 4:14 p.m., revealed the resident was prescribed a chopped diet. Review of the mealtime protocol at 4:40 p.m., revealed an order to "hand cut" the resident's meal into bite-size pieces. However, stringy vegetables should be finely chopped. A face to face interview with the Speech Pathologist on July 27, 2011, at 3:05 p.m., confirmed Resident #2 was prescribed a chopped textured diet. Further interview revealed the resident puts too much food in her mouth; therefore, the one to one staff was required to hand cut the resident's sandwich into bite size pieces. The Speech Pathologist also indicated that she will retrain the staff again August 1, 2011. The GHPID failed to ensure staff was effectively trained to implement Resident #2's mealtime protocol, as identified to address her developmental needs.	I 042		
I 090	3504.1 HOUSEKEEPING	I 090	3504.1 1. The chair will be replaced. The RD will complete monthly checks to ensure furniture is operable condition. 2. The faucet is repaired. The RD will completed monthly checks to ensure that the faucet handles are in an operable position.	9/13/11

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I 090	Continued From page 2 The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of six of six residents in the facility (Residents #1, #2, #3, #4, #5 and #6) The findings include: 1. On July 27, 2011, at 5:47 p.m., observation of the one of two loveseats in the recreation room revealed the seat moved to the right or left side when pressure was applied. Interview the residential director during this this time acknowledged the finding that the chair was in need of repair. 2. The control on the left faucet on the kitchen sink would not remain in place when the the cold water control knob was turned to an off position.	I 090		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and staff interview, the	I 095	3504.6 **This Statute will be met as evidenced by:** The QDDP will provide training to the facility RD/DSP on the correct precautions for storing chemicals.	8/31/11

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I 095	Continued From page 3 group home for persons with intellectual disabilities (GHPID) failed to ensure all caustic agents were kept in a locked cabinet and out of the direct reach of its residents as required by this section. [Residents #1, #2, #3 #4, #5, and #6] The findings include: Observation and interview with the facility's residential director (RD) on July 26, 2011 at approximately 4:00 p.m., verified there was a bottle of Windex cleaner on top of the television stand. Minutes later, a bottle of Chlorox bleach cleaner and and a bottle of Windex were observed in a unlocked cabinet below the bathroom sink. Interview with the RD at the same time revealed that all caustic agents are required to be stored in a locked cabinet.	I 095		
I 180	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: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative support to meet the habilitation needs of five of six residents in the residing in the facility. (Residents # 1,#2, #3, #4, and #6). The findings include: 1. The facility's QIDP failed to coordinate services	I 180	3508.1 This Statute will be met as evidenced by: Cross Reference W312 8/12/11 Cross Reference W249 8/31/11 Cross Reference W262.2 8/31/11 Cross Reference W436 8/31/11	

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I 180	Continued From page 4 to ensure drugs used to control inappropriate behavior were used only as an integral part of the resident's individual program plan for Residents #1 and #2. (See Federal deficiency report - Citation W312) 2. The facility's QIDP failed to coordinate services to ensure Resident #2 received continuous active treatment. (See Federal deficiency report - Citation W249) 3. The facility's QIDP failed to coordinate services to ensure that chest harnesses worn by Residents #1 and #3 were approved by the human rights committee. (See Federal deficiency report - Citation W262.2) 4. The QIDP failed to coordinate services to ensure that adaptive equipment/devices identified by the interdisciplinary team as needed for Resident #4 and #6, were maintained in good repair. (See Federal deficiency report - Citation W436)	I 180		
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	I 401	3520.3 **This Statute will be met as evidenced by:** **Cross Reference W249** 8/31/11 **Cross Reference W321** 8/12/11 **Cross Reference W331** 8/12/11	

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intellectual disabilities (GHPID) failed to ensure professional services that included 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 for one of three residents in the sample. (Resident #1)

The findings include:

The QIDP's nursing services failed to ensure that each medication was administered in compliance with the physician's orders for Resident #1, as evidenced below:

Interview with the QIDP's qualified intellectual disabilities professional (QIDP) on July 28, 2011, at 1:25 p.m. revealed Resident #1 sometimes required sedation to improve her compliance during medical appointments. The QIDP's statement was acknowledged by the registered nurse (RN).

a. Record review on July 28, 2011, at 1:35 p.m., revealed a standing order dated May 10, 2011, for Lorazepam (Ativan) 2 mg tablet , 1 tab by mouth prior to appointments.

On July 28, 2011, at 2:15 p.m., review of a nursing progress note dated June 1, 2011 (12:00 a.m. - 8:00 a.m.), revealed that Resident #1 was sedated for a 10:00 a.m. gynecological (Gyn) appointment. The review of the medication administration record (MAR) revealed that on June 1, 2011, Resident #1 was given Lorazepam (Ativan) 2 mg at 7:30 a.m. According to a nursing progress note dated May 26, 2011, however, the clinic rescheduled the appointment from June 1, 2011 to July 6, 2011. A GYN - Pap Smear

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FORM APPROVED

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0001	A. BUILDING _____ B. WING _____	07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	3020 STANTON ROAD, SE WASHINGTON, DC 20020

(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	Continued From page 8 Given verbal prompts, [the resident] will use American Sign Language for "toilet" to communicate her need to use the bathroom; (Facility Objective) [The Resident] will use six basic manual signs (eat, drink, toilet, more, sick and hurt) Monday through Friday with one additional manual sign included each quarter. At no time during the survey did the one to one staff use basic sign language to communicate with the resident, nor did the staff member encourage the use of sign language. During a face to face interview on July 27, 2011, at 3:00 p.m., the Speech Pathologist verified that Resident #2 had a basic hand signing program related to activities of daily living. Further interview revealed she will conduct training before August 1, 2011. Interview with the one to one staff on July 28, 2011, at 10:52 p.m., revealed she did not use sign language with Resident #2. Continued interview revealed she attended a sign language class in June 2011. There was no evidence that the GHPID implemented Resident #2's communication training program as recommended in the IPP.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS 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.	I 500	3523.1 This Statute will be met as evidenced by: Cross Reference W124 Cross Reference W436	8/31/11 8/31/11