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

PRINTED: 08/01/2011
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
	09G191	A. BUILDING _____ B. WING _____	07/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	2553 35TH STREET, SE WASHINGTON, DC 20024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from July 13, 2011 through July 15, 2011. A sample of two clients was selected from a population of four males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	W 000	Received 8/12/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, for one of two clients included in the sample. (Client #2) The finding includes: The facility failed to ensure Client #2's rights were protected by making certain involved family members and/or legally sanctioned medical	W 125	W125 This Standard will be met as evidenced by: On 08/08/11 the guardian provided written consent to the use of the door alarm. The consent was filed in his record. In the future the QDDP will obtain written consent before a restrictive control is implemented	8/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director of Residential Services 8/12/11

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 125	Continued From page 1 representatives assisted him with making decisions, as evidenced below: On July 13, 2011, at 6:29 p.m., observation of Client #2's bedroom door that led to the outside was observed with a door alarm. When opened, a very loud high pitch sound was heard. Interview with the direct care staff who opened Client #2's door revealed that the alarm was in place to let us know when he tried to leave the facility via his bedroom door exit. Further interview revealed that Client #2 had a behavior of elopement. The staff also added that the alarm was usually activated at 8:00 p.m. On July 15, 2011, at 9:55 a.m., review of Client #2's Behavior Support Plan (BSP) dated October 12, 2010, revealed the client had a targeted behavior of attempted elopement. Interview with the House Manager (HM) on July 15, 2011, at approximately 12:05 p.m., revealed that the alarm was placed on Client #2's door to prevent him from eloping. Further interview with the HM revealed Client #2's court appointed guardian had been made aware of the purpose of the door alarm and had agreed to its use. However, the HM stated that there was no written documentation available for review to verify that the guardian had consented to the use of the door alarm.	W 125		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence of a thorough investigation of a missing person, for one of two clients included in the sample. (Client #2) The finding includes: On July 13, 2011, at 12:34 p.m., review of the facility's incidents reports was conducted. An incident report dated January 16, 2011, revealed that at 2:05 p.m., Client #2 was missing from the home. The client was found later that day at 2:25 p.m., by direct care staff walking back to his home. Interview with the House Manager (HM) on July 13, 2011, at 4:03 p.m., and interviews with the qualified intellectual disabilities professional (QIDP) on July 15, 2011 at 1:45 p.m. revealed that the incident was investigated; however the investigation report was not available for review. Review of the facility's incident management policy (IMP) on July 15, 2011, at 1:20 p.m., revealed that all incidents are investigated. Further review of the IMC verified that all serious reportable incidents (including missing persons) required immediate notification and an investigation. At the time of the survey, however, there was no documented evidence that the aforementioned incident had been investigated.	W 154	**W154** **This Standard will be met as evidenced by:** The incident that occurred on 01/16/11 was thoroughly investigated by the Incident Management Coordinator. The IMC will be retrained by the Director of Residential Services on the timely submission of the investigation reports. The IMC will ensure the agency QDDP's are provided a copy of the investigations for the record in the home.	8/20/11
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

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W 159	Continued From page 3 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure that the active treatment program was integrated, coordinated, and monitored, for one of two clients included in the sample. (Client #2) The findings include: Cross refer to W125. The QIDP failed to ensure Client #2's rights were protected by making certain involved family members and/or legally sanctioned medical representatives assisted her with making decisions.	W 159	W159 This Standard will be met as evidenced by: Cross reference W125	8/8/11
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's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of two clients included in the sample. (Client #2) The finding includes: Cross-refer to W125. The facility failed to ensure	W 263	W263 This Standard will be met as evidenced by: Cross reference W125	8/8/11

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W 263	Continued From page 4 written informed consent was obtained from Client #2's legal guardian prior to use of the door alarm.	W 263		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On July 13, 2011, at 2:07 p.m., interview with the House Manager (HM) revealed that there were three designated shifts (6:00 AM - 2:30 PM; 2:30 PM - 11:00 PM and 11:00 PM - 7:30 AM) Monday thru Friday. Further interview revealed that there were two designated shifts (6:00 AM - 6:30 PM and 6:30 PM - 6:30 AM) for the weekend (Saturday/Sunday). Review of the facility's fire drill log records on May 18, 2011, beginning at 2:14 p.m., revealed that no drills were held during the weekday morning shift from November 2010 through January 2011. In addition, there were no fire drills held during the weekend evening shifts from August 2010 through January 2011. On July 13, 2011, at 2:52 p.m., the HM acknowledged that fire drills were	W 440	**W440** **This Standard will be met as evidenced by:** The staff will receive training on how to conduct simulated fire drills; in addition to correctly documenting drills on the appropriate fire drill log. The Residence Director will review the fire drill log weekly to ensure that all drills are being conducted per shift.	8/15/11

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W 440	Continued From page 5 not conducted on the weekend morning shift from November 2010 through January 2011 and on the evening shift from August 2010 through January 2011.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4) The finding includes: On July 13, 2011, beginning at 2:14 p.m., review of the facility's fire drill records revealed that most of the fire drills were conducted utilizing the front, back, and side door exits. Interview with the House Manager (HM) on July 13, 2011, at 2:07 p.m., revealed that the facility had at six methods of egress (front, back, side, bedroom #1, bedroom #2, and bedroom #3 exit doors). Further review of the fire drill records revealed that bedrooms #1, #2, and #3's exits had not been used since August 2010. On July 13, 2011, at 2:52 p.m., the HM acknowledged that based on the fire drill documentation, the aforementioned exits were not used during fire drills. There was no evidence on file at the time of survey to substantiate that all exits were used.	W 441	W441 **This Standard will be met as evidenced by:** The staff will receive training on using the six methods of egress during an evacuation. The fire drill documentation sheet will be revised to reflect the six (6) methods of egress for the residential facility. The Residence Director will review the fire drill documentation on a monthly basis.	8/15/11

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	HFD03-0198	A. BUILDING _____ B. WING _____	07/15/2011

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I 000	INITIAL COMMENTS A licensure survey was conducted from July 13, 2011 through July 15, 2011. A sample of two residents was selected from a population of four males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff in the resident and at two day programs, as well as a review of resident and administrative records, including incident/investigation reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for four of four residents residing in the home. (Residents #1, #2, #3, and #4) The finding includes: Observation and interview conducted with the facility House Manager (HM) on July 15, 2011, beginning at 2:24 p.m., revealed the following: Interior	I 090	**1090:** **This statute will be met as evidenced by:** IDI maintenance replaced the broken tiles in the area identified in the report. The refrigerator was thoroughly cleaned. The RD/QDDP will retrain the staff on housekeeping responsibilities. The RD will complete a monthly report to maintenance on the status of any environmental issues.	7/15/11

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I 090	Continued From page 1 A heavy build up of food, dirt, and debris was observed between the refrigerator and the kitchen Broken tiles were also observed directly behind the refrigerator. The HM acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	I 090		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure maintenance equipment was well constructed, properly maintained, and appropriate to the function for which it is to be used, for four of four residents residing in the facility. The findings include: Observation and interview with the House Manager (HM) during the environmental walk through on July 15, 2011, beginning at 2:24 p.m., revealed the following: 1. The base board located at the bottom of Client #1's door was completely broken posing a trip hazard. 2. The handrail leading from the main hall way to the second level was observed to be loose.	I 091	I091: **This statute will be met as evidenced by:** 1.) The base board was repaired by maintenance on 07/15/11.. 7/15/11 2.) The handrail was repaired by maintenance on 7/15/11 7/15/11 3.) The wall lamp was reattached in Client #3's bedroom. 4.) Staff will receive training on 08/15/11 on fire safety (removal of lint after each load). 8/15/11 5.) Maintenance cleared the lint from the exterior dryer vent. 7/15/11 The Residence Director/QDDP or designee will complete daily observations to the interior/exterior of the home to ensure that alt environmental issues/concerns are addressed in a timely manner in order to eliminate safety hazards	

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I 091	Continued From page 2 3. The wall lamp was observed to be detached from the wall located in Client #3's bedroom. 4. The dryer vent located on the dryer was observed with thick lint and the outside window payne located in the kitchen was observed to be broken. 5. The dryer vent that led to the outside was heavily packed with lint. At the end of the environmental walk-through at approximately 2:45 p.m., the HM acknowledged the above aforementioned environmental issues.	I 091		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review, the group home for intellectuall disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for four of four residents residing in the GHPID. (Residents #1, #2, #3, and #4) The finding includes: The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On July 13, 2011, at 2:07 p.m., interview with the House Manager (HM) revealed that there were three designated shifts (6:00 AM - 2:30 PM; 2:30 PM -11:00 PM and 11:00 PM - 7:30 AM) Monday thru Friday. Further interview revealed that there	I 135	1135 **This statute will be met as evidenced by:** The staff will receive training on how to conduct simulated fire drills; in addition to correctly documenting drills on the appropriate fire drill log. The Residence Director will review the fire drill log weekly to ensure that all drills are being conducted per shift	8/15/11

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I 135	Continued From page 3 were two designated shifts (6:00 AM - 6:30 PM and 6:30 PM - 6:30 AM) for the weekend (Saturday/Sunday). Review of the GHPID's fire drill log records on May 18, 2011, beginning at 2:14 p.m., revealed that no drills were held during the weekday morning shift from November 2010 through January 2011. In addition, there were no fire drills held during the weekend evening shifts from August 2010 through January 2011. On July 13, 2011, at 2:52 p.m., the HM acknowledged that fire drills were not conducted on the weekend morning shift from November 2010 through January 2011 and on the evening shift from August 2010 through January 2011.	I 135		