

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

PRINTED: 08/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2012
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, 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) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from June 13, 2012, through June 15, 2012. A sampling of three clients was selected from a population of six clients with varying degrees of intellectual disabilities. The survey was initiated utilizing the fundamental process. The findings of the survey were based on observations, interviews with a parent and a guardian, with staff in the home and at three day programs, as well as a review of the client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000	Received 7/6/12 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a complete accounting of all clients' funds for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. Interview with the house manager (Staff #7) on June 15, 2012, at approximately 2:15 p.m., revealed that the facility assisted the clients with maintaining their finances. Continued interview and review of Clients #1 and #2 bank statements	W 140	W140 This Standard will be met as evidenced by: A complete accounting of Individual's #1 and #2s financial record is maintained at IDI's accounting office. a. The outstanding balance of \$50.75 not \$50.25 was put back in to Individual #1's account 9/16/11 b. A receipt dated 9/15/11 for \$10.00 was submitted for Individual #2. The remaining balance of \$54.00 was returned to Individual's account on 11/3/11 A copy of these records has been transferred to the Individual's financial file located in the home. The RD will ensure that the financial record in the home are updated and reconciled at least monthly. The DRS will re-train the RD and QDDP in financial record keeping and "Client Funds"	6/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 7/3/12

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 140	Continued From page 1 on June 15, 2012, at 2:17 p.m., revealed each client received Supplemental Security Income (SSI) monthly. a. Review of Client #1's bank statements on June 15, 2012, beginning at 1:30 p.m., revealed no receipts for a withdrawal of \$105.00 on March 22, 2012. Continued review revealed \$180.00 was withdrawn on July 18, 2011, but the available receipts totaled \$129.25. There was no receipts or information presented to explain what happened to the remaining \$50.25. b. Review of Client #2's bank statements on June 15, 2012, beginning at 1:45 p.m., revealed a withdrawal of \$84.00 on August 22, 2011. Further review revealed there were no receipts available to justify the withdrawal. Interview with the house manager (Staff #7) and the qualified intellectual disabilities professional (Staff #8) on June 15, 2012, at approximately 2:20 p.m., revealed that the house manager that requested the aforementioned amounts was no longer employed with the facility and they were unsure how the money was spent. At the time of the survey, the facility failed to provide a complete accounting of clients personal funds.	W 140			
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.	W 436			

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W 438	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that recommended assistive devices were maintained in good repair for four of six clients residing in the facility. (Clients #1, #2, #3 and #6) The findings include: 1. The facility failed to ensure that the shower gurney mat was maintained in good condition, as evidenced below: On June 15, 2012, at 1:35 p.m., multiple cracks were observed in the pillow on the shower gurney mat. The cracks permitted water to enter the foam padding underneath the vinyl covering. The house manager (Staff #7) was present during the observation and acknowledged that there were cracks in the vinyl covering on the pillow of the shower gurney, which permitted the foam padding to get wet. The RD further stated that she would notify the (qualified intellectual disabilities professional (Staff #8) of the condition of the pillow, so that a new one could be ordered immediately. According to interview with the house manager (Staff #7), on June 15, 2012, at 1:40 p.m., the residential director revealed that the shower gurney was used during bathing of the clients. At the time of the survey, there was no evidence the facility maintained the shower gurney pillow to ensure the clients' comfort during bathing, and to	W436	This Standard will be met as evidenced by: IDI has instituted a tracking form to identify and address adaptive equipment concerns. 1. A 719 A form will be submitted to the adaptive equipment vendor to replace the torn shower gurney mat. 2. A request for repairs for Individual #6 wheelchair anti-tippers, footrest and head rest has been submitted to adaptive equipment vendor. a. The QDDP will schedule updated training for DSP on safe usage of wheelchair. The DSP's are expected to report any concerns about adaptive equipment on a monthly basis. The QDDP, RD and DSP's will be retained on the IDI's Adaptive Equipment Protocol.	7/19/12

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W 436 Continued From page 3

W 436

prevent the potential growth of bacteria.

2. Observation of Client #6 on June 15, 2012, at 12:32 p.m., revealed he leaned slightly to the side as he sat in his custom molded wheelchair. The staff was observed to reposition him upright. Further observation of the wheelchair revealed the upholstery on the bilateral footrests was taped, both anti-tippers were missing, and there was no head rest.

Interview with the QIDP (Staff #8) on June 15, 2012, at 4:10 p.m., revealed that Client #6 was reassessed by the physical therapist (PT) and that the PT recommended that the client receive a new wheelchair that had a headrest. The QIDP (Staff #8) stated that she maintained contact with the wheelchair vendor; however, the delivery date for the new chair had not been scheduled.

Record review on June 15, 2012, at 4:17 p.m., revealed the following information concerning Client #6's wheelchair:

a. October 17, 2011: Physical Therapy Evaluation - "His wheelchair is appropriate and in good condition. His wheelchair needs bilateral anti-tippers...New bilateral anti-tippers were recommended.

b. February 13, 2012: Quarterly PT Assessment - Custom molded wheelchair. "He is in need of a new seating system secondary to elevated lateral decreased support. Needs anti-tippers and a foot box. All other adaptive equipment is appropriate." The PT assessment, however, provided no instructions on how the wheelchair was to be safely used during mobility without the

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W 436 , Continued From page 4
anti-tippers.

c. February 13, 2012 : The agency equipment certification form documented that Client #6's wheelchair was examined by the wheelchair vendor. The vendor recommended anti-tippers, a new seating system, and foot boxes.

At the time of the survey, there was no evidence Client #6 received recommended repairs to his wheelchair timely.

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1 000	INITIAL COMMENTS A relicensure survey was conducted from June 13, 2012, through June 15, 2012. A sampling of three residents was selected from a population of six residents with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with a parent and a guardian, with staff in the home and at three day programs, as well as a review of the resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	1 000		
1 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was maintained in a safe and orderly manner for six of six residents in the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: On June 14, 2012, beginning at 9:20 a.m., the house manager (Staff #7) accompanied the surveyor through the facility to conduct environmental observations. The following	1 090	1090(3504.1)- This Statute will be met as evidenced by: 1. The broken tiles in the bathroom have been replaced. The RD will complete a monthly maintenance review and report any maintenance concerns to IDI's using the maintenance request form. 2. A 719 A form will be submitted to the vendor to replace the torn shower gurney mat. The DSP's are expected to report any concerns about adaptive equipment on a monthly basis. The QDDP, RD and DSP's will be retrained on the IDI's Adaptive Equipment Protocol.	7/13/12

Health Regulation & Licensing Administration

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

STATE FORM

[Signature] Director of Residential Services

7/3/12

(X6) DATE

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I 090	Continued From page 1 concerns were identified: 1. Broken tiles and caulking were observed at the base of the shower wall in the bathroom. 2. Multiple cracks were observed in the pillow on the shower gurney mat. The cracks permitted water to enter the foam padding underneath the vinyl covering. The residential director (RD) was present during the observation, and acknowledged the finding. Further observation of the pillow on June 15, 2012, at 1:35 p.m., revealed multiple cracks remained in the vinyl covering. The pillow was detached and the foam padding inside the pillow was noted to be wet. On June 15, 2012, at 1:40 p.m., the house manager (Staff #7) revealed that the shower gurney was used during bathing of the clients, and that the pillow on the shower gurney mat provided additional padding to the clients' head during bathing. At the time of the survey, there was no evidence the facility maintained the shower gurney pillow to ensure it was free of torn areas to maintain the clients' comfort during bathing, prevent water from entering the foam padding, and to prevent the potential growth of bacteria.	I 090		
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident's Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel.	I 188		

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I 188	<p>Continued From page 2</p> <p>This Statute is not met as evidenced by: Based on record review and staff interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure documentation of services provided was maintained as required by each resident's Individual Habilitation Plan, and was available for review by the authorized regulatory personnel, for two of three residents in the sample. (Residents #2 and #3)</p> <p>The findings include:</p> <p>1. Interview with the house manager (Staff #7) on June 15, 2012, at approximately 2:15 p.m., revealed that the facility assisted the residents with maintaining their finances. Continued interview and review of Residents #1 and #2 bank statements on June 15, 2012, at 2:17 p.m., revealed each resident received Supplemental Security Income (SSI) monthly.</p> <p>a. Review of Resident #1's bank statements on June 15, 2012, beginning at 1:30 p.m., revealed no receipts for a withdrawal of \$105.00 on March 22, 2012. Continued review revealed \$180.00 was withdrawn on July 18, 2011, but the available receipts totaled \$129.25. There was no receipts or information presented to explain what happened to the remaining \$50.25.</p> <p>b. Review of Resident #2's bank statements on June 15, 2012, beginning at 1:45 p.m., revealed a withdrawal of \$84.00 on August 22, 2011. Further review revealed there were no receipts available to justify the withdrawal.</p> <p>Interview with the house manager (Staff #7) and the qualified intellectual disabilities professional</p>	I 188	<p>I188(3508.6)</p> <p>This status will be met as evidenced by: Cross Reference W140</p> <p>A complete accounting of Individual's #1 and #2's financial record is maintained at IDI's accounting office.</p> <p>A1. The outstanding balance of \$50.75 not \$50.25 was put back in to Individual #1's account 9/16/11</p> <p>a & b. A receipt dated 9/15/11 for \$10.00 was submitted for Individual #2. The remaining balance of \$54.00 was returned to Individual's account on 11/3/11. A copy of these records has been transferred to the Individual's financial file located in the home. The RD will ensure that the financial record in the home are updated and reconciled at least monthly. The DRS will re-train the RD and QDDP in financial record keeping and "Client Funds."</p>

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I 188	Continued From page 3 (Staff #8) on June 16, 2012, at approximately 2:20 p.m., revealed that the house manager that requested the aforementioned amounts was no longer employed with the facility and they were unsure how the money was spent. At the time of the survey, the facility failed to provide a complete accounting of residents personal funds.	I 188		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. 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 a current health certificates was provided for one of nine consultants. (Consultant #1) The finding includes: During the entrance conference on June 13, 2012, at 7:05 p.m., the qualified intellectual disabilities professional (Staff #8) was notified of the records required to complete the survey process. Record review on June 14, 2012 at approximately 1:00 p.m., revealed no current health certificates was available for Consultant #1.	I 206	1206(3509.6) This statute will be met as evidenced by: The health certificate was received for Consultant #1. IDI's administrative staff will review the consultant records monthly. IDI will notify consultants at least month in advance that their health certificate is due to expire.	6/20/12

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I 205	Continued From page 4 Interview with the qualified intellectual disabilities professional (Staff #8) on June 14, 2012 at approximately 1:30 p.m., revealed the health certificate would be requested, and should be available on June 15, 2012. Interview with the qualified intellectual disabilities professional (Staff #8) on June 15, 2012, at 3:30 p.m., revealed that the current health certificate for Consultant #1 was still unavailable for the surveyor's review.	I 206		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. 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 each record was kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies for two of twenty-one staff of the facility. (Staff #7 and LPN #2) The finding includes: During the entrance conference on June 13, 2012, at 7:05 p.m., the qualified intellectual disabilities professional (Staff #8) was notified of the records required to complete the survey process. At that time, Staff #7 revealed that the records would be obtained from the administrative office and would be available for review on June 14, 2012. Record review on June 14, 2012 at approximately	I 201	I261(3512.2) This statute will be met as evidenced by: Staff #7 and LPN #2 personnel record were provided to the surveyor for review after the completion of the survey. Review of record indicated that the files for Staff #7 and LPN #2 were misfiled due to recent transfer from one home to another. IDI's Human Resources Director will ensure that when staff reassignments occur that their personnel files are updated and transferred to appropriate location.	7/13/12

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1261	Continued From page 5 10:45 a.m., revealed no personnel files were presented for Staff #7 and the on-call licensed practical nurse (LPN #2). Interview with Staff #7 revealed that the unavailable records would be requested from the administrative office. Further review of the personnel records on June 15, 2012, at 4:47 p.m., revealed the personal files for the aforementioned staff were still unavailable for the surveyor's review.	1261		
1474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with Intellectual disabilities (GHPID's) nursing staff failed to ensure all residents' medication administration records (MARs) reflected current and accurate information, for one of the three residents in the sample. (Resident #1) The finding includes: Review of Resident #1's written physician orders on June 15, 2012, beginning at 9:12 a.m., revealed Resident #1's Keppra 500 mg., four times daily was discontinued on April 12, 2012. On the same day, the resident's Keppra was initiated at 750 mg four times daily. However, review of the resident's day program medication administration record at approximately 10:00 a.m., revealed the aforementioned medication increase began on May 8, 2012. On June 15, 2012, at 1:13 p.m., interview with licensed practical nurse (LPN#2) revealed, the	1474	1474(3522.5) This statute will be met as evidenced by: The RN for the home will verify that the day program receives current physician's orders when any medication changes occur. A new form will be created that nursing personnel in the home and the day program will sign acknowledging receiving information about medication changes. DRS will coordinate training with day program staff to ensure day program nurses receive training on "Medication Administration, documentation and continuity of care for individuals"	7/20/12

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1474	Continued From page 6 day program received Kappa 750 mg on April 12, 2012. Further interview revealed Client #1 began receiving the aforementioned medication on April 12, 2012, but the day program failed to document the new order correctly. According to the documentation, Resident #1 began receiving Kappa 750 mg on May 8, 2012. At the time of the survey, the day program failed to document Client #1's medications accurately from April 12, 2012 to May 8, 2012.	1474		