

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

PRINTED: 04/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/08/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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{W 000} INITIAL COMMENTS

A follow-up survey was conducted on April 8, 2010 to verify that the facility had come into compliance with the Condition of Client Protections, identified in the recertification survey of March 9, 2010. Through observation, interviews with staff and clients and review of records, the determination was made that the facility had achieved substantial compliance in the Condition of Client Protections. However, standard level deficiencies remained, as evidenced in the report that follows.

{W 000}

Revised 4/25/10

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

APR 12 2010
0938-0391

{W 149} 483.420(d)(1) STAFF TREATMENT OF CLIENTS

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to develop written policies and procedures to ensure the health and safety of four of four clients residing in the facility. (Clients #1, #2, #3 and #4)

The finding includes:

On April 8, 2010, beginning at 10:45 a.m., interview with the Director of Residential Services (DRS) revealed that after the State Agency raised concerns on February 22, 2010, about a criminal background check findings indicating one of the staff was a convicted sex offender, management had initiated an internal investigation. The DRS stated that their investigation findings had revealed that the staff person in question was not the same individual that was identified in the initial

{W 149} W149

This Standard will be met as evidenced by:

The facility has written policies and procedures that prohibit mistreatment, neglect or abuse of all persons. The policies are undergoing review and currently pending approval. The proposed revisions were made to further ensure timely and systematic approaches are taken in the event there is a questionable background check.

4-25-10
england

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wm. [Signature]</i>	TITLE <i>DRS</i>	(X6) DATE 4.21.10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey, whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018		
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{W 149}	<p>Continued From page 1</p> <p>background check report. This was subsequently verified through review of the staff person's date of birth, driver's license and a secondary background check that was performed in the applicable jurisdiction; those documents were compared with information about the convicted sex offender on the website maintained by the Virginia State Police.</p> <p>The DRS stated that the facility had instituted new procedures since the March 3, 2010 survey to ensure that no persons with a history of abuse was allowed to work with clients. For example, the Human Resources Director had been instructed to fully investigate any discrepancies or concerns identified in a prospective new employees initial criminal background check. Investigation would include, but not be limited to, obtaining a secondary criminal background check, to be performed by another agency specializing in those services. Other new procedures included monthly reviews of all personnel files by the facility's quality assurance officer as well as randomly performing periodic, nationwide background checks on a sample of existing employees.</p> <p>However, when asked if the new procedures she was describing had been approved by the governing body, the DRS stated no. She indicated that meetings had been held and policy revisions were under review. She then acknowledged that their existing policy on hiring practices, dated October 1, 2003 (which she presented for review), had not yet been modified. Revised policies were yet to be adopted.</p> <p>It should be noted that interview with the Facility Coordinator, at 9:30 a.m., indicated that there had</p>	{W 149}	<p>If a questionable background check is received for any potential new hire they will not be allowed to work in the home until the matter has been resolved. The Human Resources Department in the interim has taken steps to protect and safe guard against future occurrences as evidenced by: The Human Resource Director will immediately initiate further investigation to determine the actual status of the potential applicant. A back-up agency (Absco) is being used to provide secondary information as needed. Incident Manager/QA is reviewing personnel records for compliance on a monthly basis.</p> <p>The Human Resource Department is currently implementing this procedure.</p>		

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(W 149) Continued From page 2
been no new employees hired since the March 3, 2010 survey. The most recent person hired reportedly, began employment on February 10, 2010.

Previously, the deficiency report dated March 3, 2010, included the following:

The facility failed to ensure the development/implementation of policies that prohibit the employment of individuals that have been convicted of child abuse, neglect or mistreatment, as evidenced below.

Review of staff personnel records on February 22, 2010, beginning at 4:55 p.m., revealed one of the ten staff, providing direct services to the clients, had a criminal background check that indicated he was a "sex offender (Staff #3)." Further review of the background check revealed that Staff #3 had failed to register with the sex offender registry on February 23, 2006. Interview with the Program Director (PD) on February 22, 2010, at 5:30 p.m., revealed that the staff person was still on the current schedule. The PD called the Human Resources (HR) office on February 22, 2010, at approximately 5:30 p.m., and was informed that the staff person told the HR department, "that is not me," when questioned about the criminal background check disposition. On February 23, 2010, at approximately 11:00 a.m., the PD gave the surveyor notification that the staff had been removed from the schedule.

Review of the facility personnel policy on February 23, 2010, at approximately 3:00 p.m.,

(W 149) W149
Review of the documents did not show any concerns related to staff #3's police clearance. (See attached)

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{W 149}	Continued From page 3 revealed that a police clearance must be obtained prior to employment. At the time of the survey, however, the facility failed to investigate the disposition documented on Staff #3's police clearance in order to verify that the staff was suitable to be employed.	{W 149}		
{W 255}	<p>483.440(f)(1)(I) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that the qualified mental retardation professional reviewed and revised the Individual Program Plans (IPP) once a client had successfully completed an objective, for one of two sampled clients. [Client #1]</p> <p>The finding includes:</p> <p>The facility was previously cited during the March 3, 2010, re-certification survey for failing to revise the following habilitation programs after the client had demonstrated a mastery of the skill being taught. The programs in question were as follows:</p> <p>1. "With verbal prompting, [Client #1] will complete the steps of making his bed on 100% of the trials for the month, for six consecutive months as measured by active treatment documentation."</p>	{W 255}	<p>W255</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. The program objective for making the bed was modified in January from verbal prompting to verbal cue. Program status will be evaluated and revised as needed. 2. This objective was attained in March 2010. Data collection will continue for the next quarter informal basis. <p>QMRP will review and modify all program objectives in situations in which the person has successfully completed an objective identified in the individual program plan.</p>	<p>04/12/2010</p> <p>4/22/10</p> <p>original</p>

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{W 255}	<p>Continued From page 4</p> <p>2. "With verbal prompting, [Client #1] will complete the steps of vacuuming the carpet in the basement area on 80% of the trials recorded for the month for six consecutive months as measured by active treatment documentation."</p> <p>Record review on April 8, 2010, at 12:16 p.m., revealed the following goals and objectives remained and were being implemented for the month of April 2010:</p> <p>1. Goal 2.1 [Client #1] will improve his daily living skills. Objective 2.1 "With verbal prompting, [Client #1] will complete the steps of making his bed on 100% of the trials for the month, for six consecutive months as measured by active treatment documentation by 7/10."</p>	{W 255}	<p>04/12/2010 FORM APPROVED OMB NO. 0938-0391</p> <p>04/08/2010</p>	
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	<p>Review of the April 2010 data collection sheet revealed this client's progress was being documented five days a week.</p> <p>2. Goal 2.2 [Client #1] will improve his daily living skills. Objective 2.2 "With verbal prompting, [Client #1] will complete the steps of vacuuming the carpet in the basement area on 80% of the trials recorded for the month for six consecutive months as measured by active treatment documentation by 7/10."</p> <p>Review of the April 2010 data collection sheet revealed this client's progress was being documented twice a week.</p> <p>Interview with the facility coordinator on April 8, 2010, at approximately 12:25 p.m., revealed the above programs and their corresponding data</p>		<p>04/12/2010 FORM APPROVED OMB NO. 0938-0391</p> <p>04/08/2010</p>	
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(W 255)	Continued From page 5 were current. There was no evidence presented or on file at the time of survey to substantiate that the programs had been revised since the March 3, 2010 re-certification survey.	(W 255)		PRINTED: 04/12/2010 FORM APPROVED OMB NO. 0938-0391 R 04/08/2010
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{R 000}	<p>INITIAL COMMENTS</p> <p>A follow-up survey was conducted on April 8, 2010 to verify that the facility had come into compliance with deficiencies identified in the licensure survey of March 3, 2010. Through observation, interviews with staff and residents and review of records, the determination was made that the facility had achieved substantial compliance.</p>	{R 000}		
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Health Regulation Administration

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

TITLE


(X6) DATE
 4-21-10

STATE FORM

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{1 000}	<p>INITIAL COMMENTS</p> <p>A follow-up survey was conducted on April 8, 2010 to verify that the facility had come into compliance with deficiencies identified in the licensure survey of March 3, 2010. Through observation, interviews with staff and residents and review of records, the determination was made that the facility had achieved substantial compliance. Two citations, however, remained out of compliance, as evidenced in the report that follows.</p>	{1 000}		
{1 090}	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior of the GHMRP was maintained in a clean, orderly, and attractive manner for four of the four residents residing in the facility. [Residents #1, #2, #3, and #4]</p> <p>The findings include:</p> <p>An environmental inspection was conducted on 4/8/2010 at 9:30 a.m. and the following deficient practices were observed:</p> <p>1. The hardwood floors were dirty and grimy as previously cited during the 3/3/2010 re-licensure survey.</p>	{1 090}	<p>1090</p> <p>3504.1</p> <p>This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. The hardwood floors need to be resurfaced and treated. This work is scheduled for May 2010. 2. The missing handles have been replaced. The original handles purchased did not fit and an accurate model had to be located. 3. The closet door has been assessed and is scheduled to be replaced once the hardware has been obtained. 4. All comforters have been washed. 5. The protective covers in the hall way will be replaced in the basement and main hallways. 6. An electrician has been contacted to address the shortage. 	<p>04/08/2010</p> <p>04/08/2010</p> <p>04/08/2010</p> <p>(X5) COMPLETE DATE 4-21-10 <i>original</i></p>

Health Regulation Administration
Mary Brant
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
DRS

(X6) DATE
4-21-10

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{1 090}	Continued From page 1 2. Resident #1, #3 and #4 's dressers had missing handles as previously cited during the 3/3/2010 re-licensure survey. 3. The handle to Resident #1 's closet door was broken. 4. Residue resembling bodily fluids observed on Resident #1, #2, and #4 's comforters. 5. The protective covers on the light fixtures in the main hallway and in the basement were missing. 6. The light fixture near the basement exit door appears to have an electrical shortage and flickered on and off as the staff attempted to change the bulb. Interview with the facility 's house manager (HM) on 4/8/2010 at 9:50 a.m. revealed the hardwood floors are scheduled to be resurfaced during the resident 's vacation which is scheduled to take place during the month of 5/2010. In addition, the HM also indicated that all the furniture will be replaced while the residents are out on their vacation and the wiring on the basement light fixture would be checked and repaired by an electrician as soon as possible.	{1 090}	The Home Manager will continue to monitor all outstanding repairs through completion. In addition, Home Manager will report and document maintenance concerns as they arise.	4/10/10 mgd/ina
1160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on interview and record review, the	1160	1160 3507.1 This Statute will be met as evidenced by: Reference response to W149.	4/10/10 mgd/ina

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1160	<p>Continued From page 2</p> <p>GHMRP failed to develop written policies and procedures that detailed how the facility's human resources department would ensure the health and safety needs of four of four residents of the facility. (Residents #1, #2, #3 and #4)</p> <p>The finding includes:</p> <p>On April 8, 2010, beginning at 10:45 a.m., interview with the Director of Residential Services (DRS) revealed that after the State Agency raised concerns on February 22, 2010, about a criminal background check findings indicating one of the staff was a convicted sex offender, management had initiated an internal investigation. The DRS stated that their investigation findings had revealed that the staff person in question was not the same individual that was identified in the initial background check report. This was subsequently verified through review of the staff person's date of birth, driver's license and a secondary background check that was performed in the applicable jurisdiction; those documents were compared with information about the convicted sex offender on the website maintained by the Virginia State Police.</p> <p>The DRS stated that the facility had instituted new procedures since the March 3, 2010 survey to ensure that no persons with a history of abuse was allowed to work with residents. For example, the Human Resources Director had been instructed to fully investigate any discrepancies or concerns identified in a prospective new employee's initial criminal background check. Investigation would include, but not be limited to, obtaining a secondary criminal background check, to be performed by another agency specializing in those services. Other new procedures included monthly reviews of all</p>	1160		

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I 160	<p>Continued From page 3</p> <p>personnel files by the facility's quality assurance officer as well as randomly performing periodic, nationwide background checks on a sample of existing employees.</p> <p>However, when asked if the new procedures she was describing had been approved by the governing body, the DRS stated no. She indicated that meetings had been held and policy revisions were under review. She then acknowledged that their existing policy on hiring practices, dated October 1, 2003 (which she presented for review), had not yet been modified. Revised policies were yet to be adopted.</p> <p>It should be noted that interview with the Facility Coordinator, at 9:30 a.m., indicated that there had been 10 new employees hired since the March 3, 2010 survey. The most recent person hired reportedly began employment on February 10, 2010.</p> <p>Previously, the deficiency report dated March 3, 2010, included the following:</p> <p>"Review of staff personnel records on February 22, 2010, beginning at 4:55 p.m., revealed one of the ten staff, providing direct services to the residents, had a criminal background check that indicated he was a 'sex offender.' Further review of the background check revealed that Staff #3 had failed to register with the sex offender registry on February 23, 2006. Interview with the Program Director (PD) on February 22, 2010, at 5:30 p.m., revealed that the staff person was still on the current schedule. The PD called the Human Resources (HR) office on February 22,</p>	I 160		
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I 160	Continued From page 4 2010, at approximately 5:30 p.m., and was informed that the staff person told the HR department, 'that is not me,' when questioned about the criminal background check disposition. On February 23, 2010, at approximately 11:00 a.m., the IPD gave the surveyor notification that the staff had been removed from the schedule. Review of the facility personnel policy on February 23, 2010, at approximately 3:00 p.m., revealed that a police clearance must be obtained prior to employment. At the time of the survey, however, the facility failed to investigate the disposition documented on Staff #3's police clearance in order to verify that the staff was suitable to be employed."	I 160		
{I 424}	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that the qualified mental retardation professional reviewed and revised the Individual Program Plans (IPP) once a resident had successfully completed an objective, for one of two sampled residents. [Resident #1] The finding includes: The facility was previously cited during the March 3, 2010 re-certification survey for failing to revise	{I 424}	1424 3521.5(a) This statute will be met as evidenced by: Reference response to W255.	4/22/10 angony

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/08/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018		
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{1 424}	<p>Continued From page 5</p> <p>the following habilitation programs after the resident had demonstrated a mastery of the skill being taught. The programs in question were as follows:</p> <p>1. "With verbal prompting, [Resident #1] will complete the steps of making his bed on 100% of the trials for the month, for six consecutive months as measured by active treatment documentation."</p> <p>2. "With verbal prompting, [Resident #1] will complete the steps of vacuuming the carpet in the basement area on 80% of the trials recorded for the month for six consecutive months as measured by active treatment documentation."</p> <p>Record review on April 8, 2010, at 12:16 p.m., revealed the following goals and objectives were being implemented for the month of April 2010:</p> <p>1. Goal 2.1 [Resident #1] will improve his daily living skills. Objective 2.1 "With verbal prompting, [Resident #1] will complete the steps of making his bed on 100% of the trials for the month, for six consecutive months as measured by active treatment documentation by 7/10."</p> <p>Review of the April 2010 data collection sheet revealed this resident's progress was being documented five days a week.</p> <p>2. Goal 2.2 [Resident #1] will improve his daily living skills. Objective 2.2 "With verbal prompting, [Resident #1] will complete the steps of vacuuming the carpet in the basement area on 80% of the trials recorded for the month for six consecutive months as measured by active treatment documentation by 7/10."</p>	{1 424}		

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{1 424}	Continued From page 6 Review of the April 2010 data collection sheet revealed this resident's progress was being documented twice a week. Interview with the facility coordinator on April 8, 2010, at approximately 12:25 p.m., revealed the above programs and their corresponding data were current. There was no evidence presented or on file at the time of survey to substantiate that the failure to update a resident's habilitation programs had been corrected since the March 3, 2010 re-certification survey.	{1 424}		04/08/2010