PRINTED: 08/25/2009
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G192	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 07/24/2009
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032	

(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 On June 22, 2009, at approximately 1:16 p.m., the State Agency (SA) was notified via verbal and facsimile, by the day program case manager that on the morning of June 22, 2009, Client #1 sustained an injury to his upper left eye lid while being transported to a medical appointment in the group home van. Allegedly when the transportation van exited the day program's parking lot and made a right turn onto the highway, Client #1's wheelchair tipped over sideways causing the client to hit his head on the van's left side panel. The client was assessed by the day program's nurses' and sustained a small scrape on his left upper eyelid. Client #1 was taken to the hospital emergency room via EMS as a precautionary measure. Due to the nature of the incident and further information obtained on June 22, 2009, an onsite investigation was initiated on July 17, 2009 by the SA to verify compliance with federal regulatory requirements. The findings of the investigation were based on observations at the day program and group home, interviews with one client, day program and facility staff, nursing staff, administrative staff, and a review of client and administrative records, including incident/investigation reports. As a result of the investigative findings, the SA substantiated that neglect had occurred and a determination was made that the facility failed to be in compliance with standard level requirements in Client Protection as evidenced below: (a) The facility staff had been neglectful in not	W 000	10/1/09 Received GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ____ TITLE ____ (X6) DATE 10.1.09

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 000	Continued From page 1 securing the client's wheelchair properly in the vehicle. (b) The facility failed to report the aforementioned neglect as required by the facility's policy and by federal and local regulations. (c) The facility failed to thoroughly investigate the incident (neglect). In addition, it should be noted that the facility's investigation determined neglect indicating staff training was immediately initiated June 22, 2009 on appropriately securing wheelchairs with additional training by the physical therapist on June 24, 2009 as a response to the incident.	W 000		
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 implement established procedures by generating written unusual incidents reports that impact the clients to the State Agency (SA) for one of one client in the investigation. (Client #1) The findings include: 1. The facility failed to ensure facility staff implemented its policy for writing/completing incident reports that required the involvement of emergency personnel as evidenced below:	W 149	**W149** **This Standard will be met as Evidenced by:** 1. An incident report will be written and generated for every incident. The incident report will be generated in accordance to company policies and procedures as well as state agencies. According to the QMRP the DOH was notified of the incident and during telephone conversation the monitor reported that they had received the incident report.	8-6-09 ongoing

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W 149	Continued From page 2 On July 17, 2009, at approximately 11:50 a.m., review of an Unusual Incident Report (UIR) submitted by the Day Program Case Manager (CM) as a physical injury, revealed that on the morning of June 22, 2009, Client #1 was transported to his day program with his housemates. The client remained seated in his wheelchair inside the van due to an a.m. medical appointment. While the transportation van exited the day program's parking lot and made a right turn onto the highway, Client #1's wheelchair tipped over sideways causing the client to hit his head on the van's left side panel. The client was assessed by the day program's nurses' and sustained a small scrape on his left upper eyelid. Client #1 was taken to the hospital emergency room via EMS as a precautionary measure. Interview with the Director of Residential Services/Incident Management Coordinator (DRS/IMC) on the same day at approximately 2:30 p.m. revealed that she received a phone call from the facility's Qualified Mental Retardation Professional (QMRP). Further interview with DRS/IMC revealed that the QMRP informed her that Client #1 was involved in a wheelchair accident while being transported via the facility's van to an a.m. medical appointment. The DRS/IMC stated that the day program's nursing staff after being notified by the transportation driver assessed the client until the EMS arrived. The DRS/IMC further stated that an incident report was not written by the staff involved in the incident because the day program's staff had already completed an incident report. This was confirmed through interview with the day program's Case Manager on July 20, 2009 at 12:32 p.m.	W 149	The DRS/IM/designee will monitor to ensure that an incident reports are generated by company staff and maintain verification of all correspondence forwarded. All QMRP's and/designated investigator's will receive training on the incident reporting procedures. 2. The current policy will be reviewed and modified as needed as written statements are not always requested during the interviewing process.	8·6·09 ongoing

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W 149	Continued From page 3 Additional interview with the DRS/IMC on July 17 2009, at approximately 11:00 a.m., revealed that according to their agency's policy, a written incident report should have been generated by the facility's staff who was involved in the incident on June 22, 2009. Interview with QMRP on July 20, 2009, at approximately 4:30 p.m., revealed that on June 22, 2009, at approximately 10 a.m., she received a phone call from Staff #1 (Driver) regarding Client #1 regarding the June 22, 2009 incident involving Client #1. The QMRP reiterated the account of the incident in which Client #1 sustained an injury to his left eyebrow. When asked by the surveyor if an incident report had been completed, the QMRP was aware that the incident had already been logged into the Incident Management System (IMS) by the day program. The QMRP further stated that an incident report should have been completed by the involved facility staff. On July 20, 2009, at approximately 5:00 p.m., review of the facility Incident Management Reporting Policy dated December 4, 2008, revealed "Serious Reportable Incidents (SRI) will be completed on all SRIs and forwarded by facsimile or electronic transmission within 24 hours to the Department of Health (DOH) and other local agencies". 2. The facility staff failed to ensure allegation of neglect were thoroughly investigated. According to an incident report dated June 22, 2009 and the corresponding investigation report dated June 23, 2009, Client #1's wheelchair tipped over sideways causing him to hit the van's	W 149		

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W 149	Continued From page 4 left side panel while being transported to an a.m. appointment. The day program's initial incident report was logged into the MCIS as a "physical injury". However, continued review of the internal investigation revealed that the incident was reclassified as an "allegation of neglect". The two direct care staff received disciplinary action and were immediately placed on administrative leave after the incident was reclassified. Staff #1 reportedly failed to properly tie down Client #1's wheelchair prior to transport resulting in his injury. A telephone interview conducted with the DRS/IMC on July 20, 2009, at approximately 4:29 p.m., revealed that she interviewed the two direct care staff involved in the incident at the facility's main office. When asked about the staff's written interviews and statements, the DRS/IMC stated that she did not collect any interview/written statements. Review of the investigation policy updated on December 4, 2008, revealed the internal investigators will collect the following documentary and testimonial types of evidence, if relevant: a. Testimonial - Witnesses with relevant information regarding the incident (i.e. customers, staff, or other persons) b. Documentary - Written statements There was no evidence that the facility implemented its policy for gathering testimonial/documentary evidence during an investigation. 3. Please Refer to W189. The facility failed to	W 149		

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W 149	Continued From page 5 ensure staff implemented its training policy and procedures for placement of clients while on the van lift.	W 149	W149 . continued...	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all incidents (neglect), for one of one client's being investigated. (Client #1) The finding includes: On July 17, 2009, at approximately 9:50 a.m., review of an Unusual Incident Report (UIR) submitted by the Day Program Case Manager (CM) as a physical injury, revealed that on the morning of June 22, 2009, Client #1's wheelchair tipped over sideways causing the client to hit the van's left side panel. On July 17, 2009, at 11:50 a.m., interview with the day program's Service Support Coordinator #1 (SSC #1) revealed that he had written the incident report on June 22, 2009, but did not witness the incident. SSC #1 stated that the facility's driver came back into the day program and asked for him. Upon his arrival to the facility's vehicle (located away from the day program's premises), the SSC #1 stated that Client #1's wheelchair was "flipped over" on the left side and Staff #2 was holding his head. The SSC #1 indicated that Staff #2 told him that Client #1 fell out of his wheelchair and hit his head on the side panel of the van.	W 154	3. Cross reference to W189 **W154** **This Standard will be met as evidenced by:** Reference response to W149.	8.13.09 ongoing

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W 154	Continued From page 6 On July 17, 2009, at 12:25 p.m., interview with the day program's SSC #2 revealed that he was called over to the van during Client #1's incident. The SSC #2 noticed that Client #1's wheelchair was flipped over and was not sure whether the client was secure in or out of the wheelchair. The SSC #2 stated that someone asked him to put Client #1 in the chair and "I said no, let's call 911". On July 17, 2009, at 12:25 p.m., interview with the day program's Licensed Practical Nurse (LPN) revealed she was called out of the nurse's office to assist a client who had an accident inside the van. The LPN stated that she was the first nurse to arrive. She further stated that she observed Client #1 on the floor lying on his left side with his head in Staff #2's lap. Upon her assessment, the LPN indicated that there was no swelling or bleeding noted, but a little scrape noted to the left side of the outer head. The LPN further indicated that 911 were called as a precautionary measure. On July 20, 2009, at 9:34 a.m., interview with Staff #2 revealed that on the morning of June 22, 2009, Client #1 remained seated in his wheelchair on the van while his housemates were signed into their day program. Staff #2 stated that Staff #1 came back to van and they departed from the day program. After coming off the property and making a right onto the highway, Staff #2 indicated that the van rocked and Client #1's wheelchair toppled over on its left side. On July 20, 2009, beginning at 10:25 a.m., interview with Staff #1 (driver) revealed that he secured Client #1's wheelchair in the van on the morning of June 22, 2009. Staff #1 stated that he transported Client #1 alone with three other	W 154		

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W 154	Continued From page 7 clients' to their day program site. However, Client #1 remained on the van while he unstrapped the other two clients wheelchairs. Staff #1 further stated that after he returned from signing the clients into their day program, he rechecked Client #1's wheelchairs straps to make sure they were secured. After making a right onto the highway from the day program, he stated Staff #2 yelled out to him, "Client #1's chair is moving". Staff #1 indicated that by the time he stopped the van, Client #1's wheelchair had fallen over while hitting his head on the left side panel of the van. On July 20, 2009, at approximately 5:00 p.m., review of the internal investigation dated June 23, 2009, revealed the day program's SSC was told by Staff #2 that Client #1 fell out of his wheelchair and hit his head on the van. Further review of the investigation revealed that Staff #1 reported that in order to get the other clients off the van, Client #1's chair straps had to be loosened. Staff #1 further stated that "normally he double checked all chairs prior to transport, but on this particular occasion, the van lift was not working properly and he had to manually maneuver the lift". The investigation indicated that Staff #1, while making a right turn onto the highway, Staff #2 observed Client #1's wheelchair starting to slide and tilt inside the van. Staff #1 immediately applied the brakes and stopped the van. Client #1's chair at that time rolled to the side of the van causing the chair to tilt and fall against the van's side panel with the client still strapped inside of the wheelchair. Further review of the investigation failed to show consistent statements between Staff #1 and Staff #2 interviews. For example, Staff #1 indicated that the client was secured in the wheelchair	W 154		

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W 154	Continued From page 8 when the chair tilted and Staff #2 reported to the day program's SSC #1 that the client fell out of his wheelchair. The investigation failed to evidence additional interviews and written statements with five (5) other day program staff including nurses who were involved in the care of Client #1 in some capacity. The investigation failed to include written interviews and statements from the witnesses. This was confirmed through interview with the facility's Incident Management Coordinator (IMC)/Director of Residential Services (DRS) on July 20, 2009, at approximately 5:05 p.m. Note: The facility's investigative report concluded that based on staff interview and review of the day program's incident report, it appeared that Staff #1 failed to properly tie down Client #1's wheelchair prior to transport resulting in his injury. It should be further noted that the day program's incident submitted on June 22, 2009 as a physical injury was reclassified as neglect. On July 24, 2009, at approximately 5:15 p.m., the trainer from "Coaching the Van Driver II" was interviewed by telephone. The trainer revealed that when a client is uploaded onto the van and secured properly using the 4 point tie-down, the wheelchair straps should not be loosened to unload other clients on the van. Further interview with the trainer revealed that when the 4 point tie-down is applied correctly, the wheelchair should move no more than a "half inch". The trainer stated that if a client's wheelchair tips over, that the staff applied the 4 point tie-down incorrectly.	W 154	W159 **This Standard will be met as evidenced by:** 1. All staff have received additional training on loading and unloading individuals on and off of the van. Both Managers and LPN staff assigned to the home are expected to monitor the process on a daily basis. The Fleet Coordinator also conducts random visits to the day program site to complete observations of this process. The procedures have been modified to ensure that all persons hired receive training on operating instructions of the van lift and strap downs prior to reporting to the designated group home site.	8.13.09 ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159	Note: W189: Director of Residential Services was not on	

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W 159	Continued From page 9 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, interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination and monitoring of services for one of one client (Client #1) in the investigation to include a focused client. (Client #2) The findings include: 1. Cross Refer to W149. The QMRP failed to ensure the facility implemented established procedures by generating written unusual incidents reports that impact the clients to the State Agency (SA). 2. Cross Refer to W189. The QMRP failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively. 3. Cross Refer to W193. The facility failed to ensure that Client #2's 1:1 staff remained in close proximity in accordance with his BSP.	W 159	W159, continued... site at the time of the visit and made no observations of the vehicle loading process.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 189	**W189** **This Standard will be met as evidenced by:** As indicated, additional training was provided to all of the staff assigned to the home. Managers and LPN staff will conduct ongoing monitoring and take necessary corrective actions to ensure that all staff are able to demonstrate the competency and skills needed to properly strap down and operate the vehicle lifts.	8.13.09 ongoing

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W 189	Continued From page 10 review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively for five of seven clients residing in the facility. (Clients #1, #2, #3, #4, and #5) The findings include: 1. The facility failed to ensure staff implemented its training procedures for loading and unloading clients in the vans as evidenced below: On July 17, 2009, at 4:04 p.m., Client #2 was observed being positioned onto the wheelchair lift after returning home from day program. Staff #3 backed the client onto the wheelchair lift with his back facing inward. Further observations revealed Staff #3 remained on the wheelchair lift with the client as he was lowered to ground level. On July 24, 2009, at approximately 4:07 p.m., interview with the Director of Residential Services (DRS) observed Client #2 being lowered to the ground while Staff #3 remained standing on the wheelchair lift. Review of the staff in-service training records on July 20, 2009, at approximately 2:56 p.m., revealed a training called "Coaching the Van Driver II dated January 22, 2009". The training contained operating instructions for using the wheelchair lift to include the following: a. When using the lift, wheelchair occupants should always FACE OUTWARD when entering and exiting the vehicle. b. When exiting the vehicle, NEVER back onto the platform.	W 189		

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W 189	Continued From page 11 c. The lift is designed for ONE wheelchair and its occupant. Do not overload it. d. Do not allow anyone to stand on bridge plate. Bending this bridge plate can cause dangerous interference with platform as it raises or lowers. Further review of the training record revealed that Staff #3 attended the training. 2. On July 17, 2009, at 3:28 p.m., Clients #2, #3, #4, and #5 was observed being unloaded onto the wheelchair lift after returning home from day program. The staff backed the clients onto the lift and lowered them to ground level. On July 24, 2009, beginning at 2:55 p.m., Clients #1, #2, #3, #4 and #5 was observed being unloaded onto the wheelchair lift while departing from day program. The staff backed the clients onto the wheelchair lift and lowered them to ground level. On July 24, 2009 at approximately 4:45 p.m., interview with the Qualified Mental Retardation Professional (QMRP) revealed that all staff was trained on "Coaching the Van Driver II" which included safety precautions for off/unloading clients onto the wheelchair. Further interview with the QMRP revealed that she was aware that clients should be facing outwards when entering the van; however, she stated that her staff had to do what worked for them. A telephone interview conducted with the Manager from "Coaching the Van Driver II" (Trainer) on July 24, 2009, at approximately 5:20 p.m., revealed that all clients should be up/unloaded on the van facing outwards. The Manager stated that staff should never back clients onto the wheelchair lift.	W 189		

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W 189	Continued From page 12 Review of the staff in service training records on July 20, 2009, at approximately 2:56 p.m., revealed a training called "Coaching the Van Driver II dated January 22, 2009". The training contained operating instructions for using the wheelchair lift. Further review of the training record revealed that all staff for this facility had received training.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to demonstrate competency in the implementation of client's Behavior Support Plan (BSP) for one of seven clients residing in the facility. (Client #2) The finding includes: The facility failed to ensure that Client #2's 1:1 staff remained in close proximity in accordance with his BSP as evidence below: On June 24, 2009, at approximately 2:40 p.m., the 1:1 Staff was observed pushing Client #2 in his wheelchair from the day program parking lot and into the facility's van. After securing the client's wheelchair belts, the 1:1 Staff sat in the driver's seat. At approximately 2:47 p.m., the 1:1 Staff was observed driving the van away from the day program. Interview with Client #2's 1:1 staff at approximately 2:45 p.m. revealed that he was one	W 193	**W193** **This Standard will be met as evidenced by:** QMRP will coordinate/conduct additional staff training for the 1:1 staff assigned to client #2. In addition, the designated 1:1 staff assigned to client #2 is expected to remain with him at all times. The QMRP will ensure that the one on one staff are not assigned as drivers. Further, the QMRP will monitoring and assess staff competency on all related programs and interventions for client #2.	8-20-09 ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G192		C 07/24/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	3312 4TH STREET, SE WASHINGTON, DC 20032

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W 193	Continued From page 13 of the two drivers for the day program pick-up. Interview with the Qualified Mental Retardation Professional confirmed that Client #2's 1:1 staff also serves as a driver. On July 24, 2009, at approximately 4:35 p.m., interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #2 received 1:1 staffing 24 hours a day to manage physical aggression and maladaptive behaviors. (i.e. verbal aggression, physical aggression, self-injurious behavior and property destruction. Further interview with the QMRP revealed that Client #2 has severe medical problems including seizures. Review of the BSP dated July 11, 2009 on the same day at approximately 5:45 p.m., confirmed the QMRP's interview. There was no evidence that on June 24, 2009, the facility staff demonstrated competency in the implementation of the client's BSP.	W 193		