

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

PRINTED: 04/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/14/2011
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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL DEVELOPMENT, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE WASHINGTON, DC 20019
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(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
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>On March 10, 2011, an employee of the State Surveying Agency (SSA) was in the facility to take photographs of various forms of adaptive equipment used by the clients. During his brief visit, he noted a number of potential deficiencies relative to clients' wheelchairs, which he reported upon return to the office later that afternoon.</p> <p>Due to the nature of his observations, the Health Regulation and Licensing Administration (HRLA) initiated an on-site investigation on March 11, 2011.</p> <p>The findings of this investigation were based on observations of clients' wheelchairs in the home and at two day programs, interviews with direct support staff, nurses and administrative staff in the home and at two day programs, and a review of clients' physical therapy and other habilitation records. A review of incident reports from the preceding 11 months was also conducted.</p>	W 000	<p><i>Rec'd 4/25/11</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 159	<p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure all staff received adequate training and clients were afforded the proper and necessary adaptive equipment for, three of the six clients residing in the facility. (Clients #1, #2 and #3)</p>	W 159 W 159	<ol style="list-style-type: none"> <li>1. Cross refer to 189. The QDDP scheduled training with the PT. Mr. Morse Hall, PT facilitated an in-service training for staff on mobility and transfers on 2/02/11. Training will be conducted on a semi-annually and annually basis per PT recommendation. QDDP will ensure that the training materials are filed in the home training book available for review.</li> <li>2. Cross refer to W436</li> </ol>	4/1/11 4/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Director of Residential Services	TITLE Director of Residential Services (X6) DATE 4/22/11
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A 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 those 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 159	<p>Continued From page 1</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Cross-refer to W189. The facility's QIDP failed to ensure that all staff were provided ongoing training in the area of client mobility and transfers.</li> <li>2. Cross-refer to W436. The facility's QMRP failed to ensure that Clients #1, #2 and #3 were provided the proper and necessary adaptive equipment as needed and in a timely manner.</li> </ol> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all staff was effectively trained in the area of client mobility and transfers to ensure client health and safety, for one of three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>On March 11, 2010, at 1:58 p.m., review of incident reports in the facility revealed that Client #1 sustained an injury on March 1, 2011 while his attending staff was trying to lift him out of a bathtub. According to the incident report, the client hit his face on the side of the tub and sustained a cut over his left eye. Further review of the incident report revealed that the staff took Client #1 to the nurse on duty for treatment and care.</p> <p>Continued review of incident reports, at 2:09 p.m.</p>	W 159		
W 189		W 189 W 189	<p>There was no indication that client #1 sustained an injury as a result of staff attempting to lift the client from the tub w/o utilizing the 2 person transferring technique. The QDDP indicated to an employee of HRLA that client #1 was lying on the flat bed surface of the shower bed as it was being lifted from the tub. The physical therapist will facilitate an in-service training on mobility and transfers on 04/26/11 in response to an incident that took place on 03/01/11. QDDP will schedule in-services in a timely fashion.</p>	4/26/11

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W 189	<p>Continued From page 2</p> <p>revealed that previously, on September 19, 2010, Client #1 had sustained an injury to his right great toe. According to the incident report, dried blood was observed on both sides of the toenail. The ensuing investigation report, dated September 24, 2010, included a recommendation that all staff be provided additional training in the area of mobility and transfers.</p> <p>On March 11, 2011, at 2:38 p.m., interview with Staff A (one of the facility's senior staff) revealed that client transfers should always be performed with at least two staff. Staff A further added that there should never be an instance where only one staff takes part in transferring a client from one location/seating to another.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on the same day, at 4:10 p.m., confirmed that it takes two staff to physically transfer a client from one setting to another. The QIDP also confirmed that additional staff training had been recommended in the September 24, 2010 incident investigation report.</p> <p>The facility's staff in-service training records were reviewed on March 11, 2011, beginning at 2:27 p.m. There was no documented evidence to substantiate that staff had received training on client mobility and transfers since the September 24, 2010 incident, as recommended. In addition, there was no documented training provided after the March 1, 2011 injury.</p> <p>The facility failed to ensure that there was ongoing training for staff in the area of mobility and transfers to ensure the health and safety of its clients.</p>	W 189		
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		

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W 436 - Continued From page 3

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, staff interview and record review, the facility failed to ensure that adaptive equipment was furnished and maintained in good condition as prescribed, for three of the six clients who utilized wheelchairs for mobility. (Clients #1, #2 and #3)

The findings include:

1. Interviews and review of Client #1's record revealed that the facility failed to address timely the physical therapist's recommendation that he receive a chest harness for his wheelchair, as evidenced by the following:

On March 11, 2011, at approximately 7:05 a.m., Client #1 was observed seated in his wheelchair. There was no chest harness visible. When asked, the two direct support staff who were with Client #1 at the time (Staff A and B) stated that he had a chest harness and had worn it to his day program on the day before. Staff B indicated that the harness had been washed overnight and she left the living room to retrieve it. A few moments later, the overnight licensed practical nurse (LPN) and two direct support staff (Staff B and C) were interviewed in the dining room. They all stated that chest harnesses should be fastened while

W 436

W 436

1. A 719A Form was completed by the QDDP for submission to the w/c vendor. Mr. Morse Hall, PT assessed the w/c of client #1 on 03/11/11. Mr. Hall's assessment recommended the installation of a chest harness and head rest as "optional, additional safety measures" as evidenced in the PT progress note. The ODDP will follow the established protocol to ensure timely acquisition of adaptive equipment.

3/11

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W 436 Continued From page 4  
traveling in the van, to ensure safety. After breakfast, Staff B draped a chest harness loosely over the client's left shoulder but did not fasten it.

The qualified intellectual disabilities professional (QIDP) was interviewed by telephone on March 11, 2011, at approximately 8:20 a.m. She stated that to her knowledge, Client #1's wheelchair was "ok."

At 8:29 a.m., Client #1 was observed in the facility van. Staff A and D were securing the four tie-down straps and a long, black lap belt to Client #1's wheelchair. Once he was secured, they began loading another client onto the van.

At approximately 8:34 a.m., the daytime LPN came outside and asked the staff whether any of the clients' wheelchairs were "not fixed properly," to which Staff A replied "no." The LPN then asked if Client #1 had a chest harness. Staff A and D inspected Client #1's wheelchair and replied "no," informing her that they could not locate one of the straps needed to secure the chest harness. The LPN instructed the staff to remove Client #1 from the van, stating that this was to ensure the client's safety. He would stay home from day program that day.

Later that morning, beginning at 10:41 a.m., review of Client #1's record revealed that his most recent physical therapy assessment, dated August 16, 2010, included a wheelchair evaluation form (same date). The physical therapist's recommendations included: "repair hydraulics...install chest harness." There was no evidence that the PT's recommendations to install a chest harness or repair the hydraulics had been addressed.

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W 436	<p>Continued From page 5</p> <p>It should be noted that on March 14, 2011, beginning at 10:04 a.m., Client #1 was observed at his day program. There was no chest harness on his wheelchair. His longtime (two years) day program activities coordinator and the instructor who had worked with the client for approximately four months both stated that they had never observed him with a chest harness on the wheelchair. Neither staff could recall any discussions regarding the need for a chest harness.</p> <p>2. The facility failed to implement a system to ensure timely maintenance and repair of clients' wheelchairs, as evidenced by the following:</p> <p>On March 11, 2011, at 8:07 a.m., inspection of the back side of Client #1's wheelchair revealed that there was no anti-tipper device on the right side. The left anti-tipper device was pointed upwards. At 8:08 a.m., the daytime LPN and Staff A looked at the rear of his wheelchair, confirmed the surveyor's observations and stated that they had not been previously aware that the anti-tippers were missing and/or not positioned properly.</p> <p>Interview with the QIDP, at 8:20 a.m., revealed that she was unaware of any problems with Client #1's wheelchair. At approximately 8:34 a.m., interview with Staff A revealed that staff were expected to report any wheelchair maintenance concerns to the house manager who, in turn should notify the QIDP. Later that morning, beginning at 10:41 a.m., review of Client #1's record revealed no indication that the client's wheelchair anti-tippers had been inspected.</p>	W 436	<p>2. A 719A form has been submitted for the repair of Client #1 anti-tippers. Staff will receive training from the PT on 4/26/11 and continue to document and verbally report any concerns with adaptive equipment. QDDP has resubmitted a 719A form for Client #2 wheelchair.</p>	4/26/11

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W 436	<p>Continued From page 6</p> <p>3. Interviews and review of Client #2's record revealed that the facility failed to address timely the physical therapist's recommendation that he receive a custom wheelchair, as evidenced by the following:</p> <p>On March 11, 2011, at 7:29 a.m., Client #2 was observed seated in his wheelchair in the dining room. Staff were feeding him breakfast. Interview with the overnight LPN and Staff C revealed that a technician had taken measurements and Client #2 was due to receive a replacement wheelchair. Observation of the current wheelchair revealed that both footrests were torn and frayed, the plastic knob handles were missing from both of the manual brakes (wheel stops), and the right tilt trigger (used to adjust the angling of his wheelchair) was looser than the one on the left.</p> <p>The QIDP was interviewed in the facility, beginning at 10:10 a.m. She stated that she was aware that some parts on Client #2's wheelchair needed repair. She further indicated that the facility was seeking an entirely new wheelchair, given that 5 years had passed since he received a new one.</p> <p>Client #2's physical therapy and adaptive equipment records were reviewed on March 11, 2011, beginning at 1:14 p.m. On April 30, 2009, the PT wrote a progress note in which he recommended a "new custom molded seating system and wheelchair with needed accessories." The PCP Initialed the progress note but did not date it and there was no documentation of a corresponding 719A form. Client #2's record included a letter dated July 20 2010, in which the wheelchair vendor informed the facility that they</p>	W 436	<p>3. The QDDP for the home has submitted another 719A request for a new wheelchair for Client #2. The QDDP will review all assessments submitted by each discipline to ensure all recommendations, to include repairs and acquisition, are addressed in a timely manner.</p>	3/17/11
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were having "financial problems... we have completed the work of sizing and custom molding...we cannot order the completed system at this time."

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Client #2's records reflected that on August 9, 2010, the PCP wrote a prescription for "wheelchair with custom molded seating system. " A 719A form was generated by the nurse practitioner on next next day (August 10, 2010); however, the form did not correspond with the prescribed seating system. Instead, the 719A form was to "repair left and right brake handles, stabilize right reclining lever, and stabilize rear wheels." According to a QIDP progress note, dated August 26, 2010, the facility identified a new vendor. On October 26, 2010, the PCP wrote another prescription that was identical to the one he had written on August 9, 2010. Client #2's record reflected a 719A form for a "new custom molded wheelchair" that was signed (but not dated) by the nurse practitioner. Continued review of the record failed to provide clarity as to why Client #2 remained without a custom molded wheelchair in March 2011.

4. On March 11, 2011, at 7:23 a.m., Client #3 was observed seated in his wheelchair in the living room. The right anti-tipper device was pointing inwards, towards the left rear wheel. Similarly, the left anti-tipper device was pointing towards the right wheel. Staff B stated that someone had been in the facility approximately one month earlier and that the anti-tippers needed to be replaced. A form 719A reportedly had been completed and an order placed. Moments later, Staff B stated that the anti-tippers "need to be adjusted." The overnight LPN stated that Client #3 had a meeting scheduled for 10 a.m. in the

4. A 719A form has been submitted for the repair of Client#3 anti-tippers. The QDDP will review all assessments submitted by each discipline to ensure all recommendations, to include repairs and acquisition, are addressed in a timely manner.

3/11/11

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W 436 Continued From page 8  
facility; therefore, he would not go to day program that morning.

The QIDP was interviewed shortly after her arrival, beginning at 10:10 a.m. She indicated that the wheelchair used by Client #3 was in good repair. She further indicated that staff had not informed her of any problems with the client's wheelchair. Later that day, beginning at 3:25 p.m., review of Client #3's record revealed no indication that the client's wheelchair anti-tippers had been inspected and/or found deficient.

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	<p><b>1 000 INITIAL COMMENTS</b></p> <p>On March 10, 2011, an employee of the Health Regulation and Licensing Administration (HRLA) was in the facility to take photographs of various forms of adaptive equipment used by the residents. During his brief visit, he noted a number of potential deficiencies relative to residents' wheelchairs, which he reported upon return to the office later that afternoon.</p> <p>Due to the nature of his observations, HRLA initiated an on-site investigation on March 11, 2011.</p> <p>The findings of this investigation were based on observations of residents' wheelchairs in the home and at two day programs, interviews with direct support staff, nurses and administrative staff in the home and at two day programs, and a review of residents' physical therapy and other habilitation records. A review of incident reports from the preceding 11 months was also conducted.</p>		
<p><b>1 160 3507.1 POLICIES AND PROCEDURES</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to have a written policies and procedures manual on site and available for review by staff on the first day of the complaint investigation.</p> <p>The finding includes:</p>	<p><b>1 160</b></p>	<p><b>1 160</b></p>	<p>Director of Residential Services will ensure that there is a Policy and Procedure Manual available for all homes. The availability of the Policy Procedure Manual will be monitored during IDI's Quality Assurance Department.</p> <p><b>4/30/11</b></p>

Health Regulation Administration

*[Signature]* Director of Residential Services  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X5) DATE  
**4/22/11**

DATE FORM

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I 160	Continued From page 1  On March 11, 2011, at 9:09 a.m., the daytime licensed practical nurse (LPN) and direct support staff agreed to provide the policies and procedures manual. Specific policies that were requested included Adaptive Equipment, Transportation, and Incident Reporting policies. At 3:22 p.m., the qualified intellectual disabilities professional (QIDP) agreed to seek the facility's policies and procedures manual. At 3:55 p.m., the QIDP stated that she was unable to locate a policies and procedures manual in the facility. In addition to those requested earlier, a request was made to see the policies regarding transfers and mobility. A QIDP assigned to another facility operated by the same governing body reportedly would bring a policies manual from the other facility. However, no manual was presented for review before surveyors left the GHPID at 5:21 p.m. on March 11, 2011.	I 160		
I 162	3507.3 POLICIES AND PROCEDURES  The manual shall be available for review and approval by District of Columbia personnel who have licensing, supervisory, monitoring and certification responsibility.  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 make available for review their policies and procedures manual.  The finding includes:  Cross-refer to I160. On March 11, 2011, at 9:09 a.m., facility staff agreed to provide the policies and procedures manual. Additional requests were made during the course of the day;	I 162	I 162 See responses to I160	4/30/11

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I 162	Continued From page 2  however, no manual was presented for review before surveyors left the GHPID that evening at 5:21 p.m.	I 162		
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, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet the needs of three of the six residents of the facility. (Residents #1, #2 and #3)  The findings include:  1. Cross-refer to I229. The facility failed to ensure that all staff were provided ongoing training in the area of client mobility and transfers, as recommended by the GHDP's incident management coordinator.  2. Cross-refer to WI500. The facility failed to ensure that Residents #1, #2 and #3 were provided the proper and necessary adaptive equipment as needed and in a timely manner.	I 180	I 180 1. See response to I 229 2. See response I 500	4/26/11 8/30/11
I 229	3510.5(f) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited	I 229	I 229 Staff had received training on mobility transfers on 2/2/11. The QDDP will ensure that staff training records are filed in the training record in the home. Additionally the QDDP will ensure that staff receive timely training after an incident occurs. PT is scheduled to complete a refresher training on mobility and transfers on 4/26/11	4/26/11

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I 229	Continued From page 3  to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all staff was effectively trained in the area of resident mobility and transfers to ensure resident health and safety, for one of three residents in the sample. (Resident #1)  The findings include:  On March 11, 2010, at 1:58 p.m., review of incident reports in the facility revealed that Resident #1 sustained an injury on March 1, 2011 while his attending staff was trying to lift him out of a bathtub. According to the incident report, the resident hit his face on the side of the tub and sustained a cut over his left eye. Further review of the incident report revealed that the staff took Resident #1 to the nurse on duty for treatment and care.  Continued review of incident reports, at 2:09 p.m. revealed that previously, on September 19, 2010, Resident #1 had sustained an injury to his right great toe. According to the incident report, dried blood was observed on both sides of the toenail. The ensuing investigation report, dated September 24, 2010, included a recommendation that all staff be provided additional training in the area of mobility and transfers.  On March 11, 2011, at 2:38 p.m., interview with Staff A (one of the facility's senior staff) revealed that resident transfers should always be performed with at least two staff. Staff A further added that there should never be an instance	I 229		

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1229	Continued From page 4  where only one staff takes part in transferring a resident from one location/seating to another.  Interview with the qualified intellectual disabilities professional (QIDP) on the same day, at 4:10 p.m., confirmed that it takes two staff to physically transfer a resident from one setting to another. The QIDP also confirmed that additional staff training had been recommended in the September 24, 2010 incident investigation report.  The facility's staff in-service training records were reviewed on March 11, 2011, beginning at 2:27 p.m. There was no documented evidence to substantiate that staff had received training on resident mobility and transfers since the September 24, 2010 incident, as recommended by the incident management coordinator. In addition, there was no documented training provided after the March 1, 2011 injury.  The facility failed to ensure that there was ongoing training for staff in the area of mobility and transfers to ensure the health and safety of its residents.	1229		
1500	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.  This Statute is not met as evidenced by: Based on observations, staff interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to observe and protect residents' rights in accordance with	1500		

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I 500	Continued From page 5  Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectual disabilities, for three of the six residents who utilized wheelchairs for mobility. (Residents #1, #2 and #3)  The findings include:  The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both consistent with the recommendations included in the resident's individual support plan (ISP), for three of the six residents of the GHPIID. [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)] as follows:  1. Interviews and review of Resident #1's record revealed that the facility failed to address timely the physical therapist's recommendation that he receive a chest harness for his wheelchair, as evidenced by the following:  On March 11, 2011, at approximately 7:05 a.m., Resident #1 was observed seated in his wheelchair. There was no chest harness visible. When asked, the two direct support staff who were with Resident #1 at the time (Staff A and B) stated that he had a chest harness and had worn it to his day program on the day before. Staff B indicated that the harness had been washed overnight and she left the living room to retrieve it. A few moments later, the overnight licensed practical nurse (LPN) and two direct support staff (Staff B and C) were interviewed in the dining room. They all stated that chest harnesses should be fastened while travelling in the van, to ensure safety.	I 500	I 500  1. According to the PT's latest assessment Resident #1 chest harness is "optional, additional safety measures" The QDDP will review all assessments submitted by each discipline to ensure all recommendations, to include repairs and etc, are addressed in a timely manner.	3/30/11

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1500	<p>Continued From page 6</p> <p>The qualified intellectual disabilities professional (QIDP) was interviewed by telephone on March 11, 2011, at approximately 8:20 a.m. She stated that to her knowledge, Resident #1's wheelchair was "ok."</p> <p>At 8:29 a.m., Resident #1 was observed in the facility van. Staff A and D were securing the four tie-down straps and a long, black lap belt to Resident #1's wheelchair. Once he was secured, they began loading another resident onto the van.</p> <p>At approximately 8:34 a.m., the daytime LPN came outside and asked the staff whether any of the residents' wheelchairs were "not fixed properly," to which Staff A replied "no." The LPN then asked if Resident #1 had a chest harness. Staff A and D inspected Resident #1's wheelchair and replied "no," informing her that they could not locate one of the straps needed to secure the chest harness. The LPN instructed the staff to remove Resident #1 from the van, stating that this was to ensure the resident's safety. He would stay home from day program that day.</p> <p>Later that morning, beginning at 10:41 a.m., review of Resident #1's record revealed that his most recent physical therapy assessment, dated August 16, 2010, included a wheelchair evaluation form (same date). The PT assessment, which was incorporated in the resident's ISP, included the recommendation to: "repair hydraulics...install chest harness." There was no evidence that the PT's recommendations to install a chest harness or repair the hydraulics had been addressed.</p> <p>It should be noted that on March 14, 2011, beginning at 10:04 a.m., Resident #1 was observed at his day program. There was no</p>	1500		

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	<p>Continued From page 7</p> <p>chest harness on his wheelchair. His longtime (two years) day program activities coordinator and the instructor who had worked with the resident for approximately four months both stated that they had never observed him with a chest harness on the wheelchair. Neither staff could recall any discussions regarding the need for a chest harness.</p> <p>2. The facility failed to implement a system to ensure timely maintenance and repair of residents' wheelchairs, as evidenced by the following.</p> <p>On March 11, 2011, at 8:07 a.m., inspection of the back side of Resident #1's wheelchair revealed that there was no anti-tipper device on the right side. The left anti-tipper device was pointed upwards. At 8:08 a.m., the daytime LPN and Staff A looked at the rear of his wheelchair, confirmed the surveyor's observations and stated that they had not been previously aware that the anti-tippers were missing and/or not positioned properly.</p> <p>Interview with the QIDP, at 8:20 a.m., revealed that she was unaware of any problems with Resident #1's wheelchair. At approximately 8:34 a.m., interview with Staff A revealed that staff were expected to report any wheelchair maintenance concerns to the house manager who, in turn should notify the QIDP. Later that morning, beginning at 10:41 a.m., review of Resident #1's record revealed no indication that the resident's wheelchair anti-tippers had been inspected.</p> <p>3. Interviews and review of Resident #2's record revealed that the facility failed to address timely the physical therapist's recommendation that he</p>		<p>2. A 719A form has been submitted for the repair of Client #1 anti-tippers. Staff will receive training from the PT on 4/26/11 and continue to document and verbally report any concerns with adaptive equipment. <span style="float: right;">4/26/11</span></p> <p>3. The QDDP for the home has submitted another 719A request for a new wheelchair for Client #2. The QDDP will review all assessments submitted by each discipline to ensure all recommendations, to include repairs and acquisition, are addressed in a timely manner. <span style="float: right;">3/17/11</span></p>

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1500	Continued From page 8  receive a custom wheelchair, as evidenced by the following:  On March 11, 2011, at 7:29 a.m., Resident #2 was observed seated in his wheelchair in the dining room. Staff were feeding him breakfast. Interview with the overnight LPN and Staff C revealed that a technician had taken measurements and Resident #2 was due to receive a replacement wheelchair. Observation of the current wheelchair revealed that both footrests were torn and frayed, the plastic knob handles were missing from both of the manual brakes (wheel stops), and the right tilt trigger (used to adjust the angling of his wheelchair) was looser than the one on the left.  The QIDP was interviewed in the facility, beginning at 10:10 a.m. She stated that she was aware that some parts on Resident #2's wheelchair needed repair. She further indicated that the facility was seeking an entirely new wheelchair, given that 5 years had passed since he received a new one.  Resident #2's physical therapy and adaptive equipment records were reviewed on March 11, 2011, beginning at 1:14 p.m. On April 30, 2009, the PT wrote a progress note in which he recommended a "new custom molded seating system and wheelchair with needed accessories." The PCP initialed the progress note but did not date it and there was no documentation of a corresponding 719A form. Resident #2's record included a letter dated July 20, 2010, in which the wheelchair vendor informed the facility that they were having "financial problems... we have completed the work of sizing and custom molding... we cannot order the completed system at this time."	1500		

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1500	<p>Continued From page 9</p> <p>Resident #2's records reflected that on August 9, 2010, the PCP wrote a prescription for "wheelchair with custom molded seating system..." A 719A form was generated by the nurse practitioner on next next day (August 10, 2010); however, the form did not correspond with the prescribed seating system. Instead, the 719A form was to "repair left and right brake handles, stabilize right reclining lever, and stabilize rear wheels." According to a QIDP progress note, dated August 26, 2010, the facility identified a new vendor. On October 26, 2010, the PCP wrote another prescription that was identical to the one he had written on August 9, 2010. Resident #2's record reflected a 719A form for a "new custom molded wheelchair" that was signed (but not dated) by the nurse practitioner. Continued review of the record failed to provide clarity as to why Resident #2 remained without a custom molded wheelchair in March 2011.</p> <p>4. On March 11, 2011, at 7:23 a.m., Resident #3 was observed seated in his wheelchair in the living room. The right anti-tipper device was pointing inwards, towards the left rear wheel. Similarly, the left anti-tipper device was pointing towards the right wheel. Staff B stated that someone had been in the facility approximately one month earlier and that the anti-tippers needed to be replaced. A form 719A reportedly had been completed and an order placed. Moments later, Staff B stated that the anti-tippers "need to be adjusted." The overnight LPN stated that Resident #3 had a meeting scheduled for 10 a.m. in the facility; therefore, he would not go to day program that morning.</p> <p>The QIDP was interviewed shortly after her arrival, beginning at 10:10 a.m. She indicated that</p>	1500	<p>4. A 719A form has been submitted for the repair of Client#3 anti-tippers. The QDDP will review all assessments submitted by each discipline to ensure all recommendations, to include repairs and acquisition, are addressed in a timely manner.</p>	3/18/11

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I 500	Continued From page 10  the wheelchair used by Resident #3 was in good repair. She further indicated that staff had not informed her of any problems with the resident's wheelchair. Later that day, beginning at 3:25 p.m., review of Resident #3's record revealed no indication that the resident's wheelchair anti-tippers had been inspected and/or found deficient.	I 500		