

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/04/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>On July 27, 2010, the State Surveying Agency's (S:IA) Office of Compliance and Quality Assurance and Investigation Division (OCQAID), received notification via voicemail, followed by a written report, of an incident that occurred on the same day involving Client #1. According to the information provided, the client sustained a closed head injury as the result of a fall.</p> <p>Based on the nature of the incident, the OCQAID initiated an on-site investigation on August 4, 2010, to ensure federal and state regulations were adhered to in accordance with Client #1's needs. The results of the investigation revealed that the facility failed to maintain compliance with the Conditions of Participation of Governing Body, Client Protections, and Facility Staffing. The facility's failure to provide necessary supervision and support to Client #1 and its failure to implement systems to prevent further potential harm posed likely harm to the clients residing in the facility. The Facility Coordinator (FC) and the Qualified Mental Retardation Professional (QMRP) were notified that an Immediate Jeopardy existed on August 4, 2010, at approximately 4:28 p.m.</p> <p>Prior to exiting the facility on August 4, 2010, the facility developed a plan of correction to lift the jeopardy that consisted of the following:</p> <ul style="list-style-type: none"> • Staff #1 will immediately be removed from all customer contact as of August 4, 2010; • The QMRP and Facility Coordinator will conduct immediate staff in-service on safety and procedures for the shower area; • Additional in-service will be conducted on the shower protocol; 	W 000		
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GOVERNMENT OF THE DISTRICT OF COLUMBIA
 DEPARTMENT OF HEALTH
 HEALTH REGULATION ADMINISTRATION
 825 NORTH CAPITOL ST., N.E., 2ND FLOOR
 WASHINGTON, D.C. 20002
 9-8-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE DPS	(X6) DATE 9/8/10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 4354 ASTOR PLACE, SE WASHINGTON, DC 20019		
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W 000	Continued From page 1 - In-service will be conducted on policies and procedures in general safety of customers and not leaving them unattended during shower time; - Immediate in-service on staff supervision and remaining in any area where individuals are present at all times. Although the facility removed the serious and immediate threat to clients' health and safety, the Conditions of participation in Governing Body, Client Protections and Facility Staffing continued to remain unmet. The findings of the investigation were based on observations at the group home, interviews with the staff and the review of records including the facility's unusual incident reports.	W 000			
W 102	483 410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	W102 This CONDITION will be met as evidenced by:	08-10 ongoing	
W 104	This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility's Governing Body failed to maintain general operating direction over the facility, [See W104] and failed to ensure effective training programs were developed and implemented to ensure client safety. [See W189]. The affects of these systematic practices resulted in the governing body's failure to manage the facility in a manner that would ensure clients' health and safety. [See W122 and W158]	W 104	Reference responses to W104 and W189, W122 and W158.		
	483 410(a)(1) GOVERNING BODY				

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W 104	Continued From page 2 The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review the Governing Body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report, for eight of eight clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, #7, and #8). The findings include: 1. The Governing body failed to ensure that staff were effectively trained in providing transfer assistance to clients requiring a two-person transfer. (See W189) 2. The Governing Body failed to develop and implement policies and procedures to ensure client safety. (See W149)	W 104	W104 This Standard will be met as evidenced by: 1. Reference response to W189. 2. Reference responses to W149.	9-8-10 ongoing
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to develop and/or implement their incident management policy to make certain abuse, neglect or mistreatment was prohibited and failed to develop policies and procedures to prevent abuse and neglect (see W149); failed to ensure allegations of abuse and neglect were thoroughly investigated (See W154); failed to protect clients	W 122		

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W 104	<p>Continued From page 2</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the Governing Body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report, for eight of eight clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The Governing body failed to ensure that staff were effectively trained in providing transfer assistance to clients requiring a two-person transfer. [See W189] 2. The Governing Body failed to develop and implement policies and procedures to ensure client safety. [See W149] 	W 104		
W 122	<p>485.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to develop and/or implement their incident management policy to make certain abuse, neglect or mistreatment was prohibited and failed to develop policies and procedures to prevent abuse and neglect (see W149); failed to ensure allegations of abuse and neglect were thoroughly investigated (See W164); failed to protect clients</p>	W 122	<p>W122</p> <p>This CONDITION will be met as evidenced by:</p> <p>Reference responses to W149, W154, W155, W156, and W158.</p>	<p>9.8.10</p> <p>ongoing</p>

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W 122	Continued From page 3 from further potential abuse while an allegation of abuse was investigated (See W155); and failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident (See W156). The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety. (Cross Refer W158)	W 122	W127 This Standard will be met as evidenced by: As documented in the findings, client #1 sustained "small bump" injury to her forehead. She was diagnosed with a closed head injury- contusion. The person did not require further testing in the emergency room and did not show any evidence of pain or discomfort at the time of the incident. Other signs and symptoms such as convulsions, nose bleeds, and change in mental status were not noted. Additionally, there was no evidence of severe or permanent injury or harm to the mental or physical condition of the person.	9.8.10 on going
W 127	48: 420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to make certain clients were not subjected to actual or potential neglect and/or physical injury, for eight of eight clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8) The findings include: On July 27, 2010, Health Regulations and Licensing Administration was notified via voicemail of an unusual incident report involving Client #1. According to the incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. The incident report described the incident as	W 127		

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W 127	<p>Continued From page 4 documented below.</p> <p>" I [Staff #1], had put Client #1 in her shower chair located the shower chair belts in place and pulled the shower chair over the toilet to help her urinate before putting her in her wheelchair. I stepped out of the bathroom to get something. When I got back to Client #1 she was sitting on the floor. I asked the nurse to check Client #1 to see if she was hurt."</p> <p>LPN #1 assessed Client #1 and documented the following:</p> <p>"Head to toe assessment done. Observe an elevated area on the left forehead in size of a penny. No bleeding, no open area. V/S (vital signs) check - T [temperature] 97.2, R [respirations] 18, B/P [blood pressure] 117/70 and P [pulse] 75. Supervisor, Nurse Practitioner, QMRP [Qualified Mental Retardation Professional], PCP, House Manager notified."</p> <p>Review of the facilities corresponding investigative report (dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m. revealed the facility documented findings including:</p> <ul style="list-style-type: none"> Client #1 sustained the injury to her forehead as a result of falling to the floor while left unattended sitting on a shower chair positioned over the commode. Progress note dated July 27, 2010 (8 a.m.) revealed nurse assessed Client #1 and noted a small bump on the right side of her forehead. Ice compress was applied and the nurse practitioner (NP) and primary care physician was notified. NP gave instruction to transport Client #1 to the emergency department. Emergency Department discharge 	W 127	<p>W127,</p> <p>Person #1 received immediate medical care and assessment. She was followed up with the RN, Primary Care Physician and Nurse Practitioner who also determined that no further interventions were warranted. Person #1 has a diagnosis of Osteoporosis but did not sustain any injuries related to this diagnosis.</p> <p>The Incident Management Coordinator entered the information into the DDS MCIS system as a reportable incident, as the person sustained a minor physical injury to her forehead.</p>	<p>9.8.10</p> <p>ongoing</p>
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W 127	<p>Continued From page 5</p> <p>instructions included Client #1's intake diagnoses as an abrasion to her forehead, closed head injury, and contusion. Further review of the investigative report revealed that Client #1 was at risk for falls and is diagnosed with Osteoporosis. " Risk management procedures indicated that staff should adhere to safety techniques at all times in bed and chair and adhere to recommended transfer techniques as outlined in physical therapy evaluation. The physical therapy evaluation states that [Client #1] transfers with maximum assistance of two people and [Client #1] can sit in a chair with arms or recliner with supervision. " Continued review of the investigation report revealed that the direct care staff person that assisted Client #1 to the restroom indicated that she left Client #1 in the restroom alone, secured with a seatbelt on a shower chair, above the toilet. This staff person further indicated that when she returned to the restroom she found Client #1 " sitting on the floor " in an upright position with the shower chair seatbelt still around the client, loose and laying on the floor. The shower chair, however, was observed to remain positioned over the toilet. Additionally, it was noted that Staff #1 " picked [Client #1] up off the floor and sat her on the shower chair. " Staff #1 then pushed [Client #1] to her room and then transferred her from the shower chair to the bed. " The investigator, conversely, documented that after examination of the shower chair seatbelt, it was noted that " the belt is not long enough to be able to extend to the floor. In addition, if the belt was secured and still around [Client #1's] waist as Staff #1 stated, the shower chair would have moved out of position from over the commode. Moreover, Staff #1 should not have picked [Client #1] from the floor by self and without the nurse first examining</p>	W 127	<p>The incident report was accepted in the MCIS as a reportable incident. The NP ordered that person #1 be further evaluated at ER as a precaution. Person #1 was evaluated and released. No further testing such as X-Ray or CT Scan was recommended or required. The Incident Management Coordinator initiated and conducted the investigation.</p> <p>Also, as documented in the investigation the staff person conducted lifting and transfer techniques which were inconsistent with the recommended guidelines. She also left the person unattended violating company policy and procedures.</p> <p>The employee involved in the incident as well as other assigned staff received training on the morning of July 27th by the Home Manager and was not determined to present a serious and immediate threat to the persons served.</p> <p>9.8.10 ongoing</p>

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W 127	<p>Continued From page 6</p> <p>[Client #1] due to her diagnosis of Osteoporosis and potential for fractures." The investigation report further documented that the incident was preventable.</p> <p>The investigation report highlighted the following recommendations:</p> <ul style="list-style-type: none"> Corrective action for responsible staff person for not following transfer protocol as stated in the Physical Therapy Evaluation. Note: Interview with the House Manager and Qualified Mental Retardation Professional on August 4, 2010, revealed that the corrective action was to immediately place Staff #1 on administrative leave. Corrective action for responsible staff person for not following sitting protocol as stated in Physical Therapy Evaluation. <ul style="list-style-type: none"> In-service training for all staff on transfers. In-service training for all staff on HMCP (Risk Area: Musculo-Skeletal). Follow emergency department discharge instructions. Follow-up with PCP. Follow PCP recommendations. <p>1. The facility failed to ensure staff provided supervision in accordance with Client #1's needs.</p> <p>According to the aforementioned incident report, Staff #1 left Client #1 unsupervised while in the restroom. Interview with the QMRP on August 4, 2010, at approximately 4:41 p.m. revealed that Staff #1 should not have left Client #1 unsupervised while on the toilet. This information was verified through review of Client #1's physical therapy assessment dated July 21, 2009 on August 4, 2010, at approximately 2:30 p.m. The assessment documented that Client #1 "can sit in a chair with arms or recliner with supervision."</p>	W 127	<p>Further review of the incidents occurring at this group home location over the past three-six month period show no systemic patterns of abuse & neglect.</p> <p>The Incident Management Coordinator has consistently monitored and tracked all incidents for patterns and makes recommendation to address systemic findings.</p> <p>The employee has received disciplinary action for failing to adhere to company policy and procedures as well as potentially jeopardizing the health and safety of the person.</p> <p>The QMRP/Home Manager coordinated additional staff training on HMCP, Incidents, Reporting Incidents, Abuse & Neglect, client rights/sensitivity, safe transfer & lifting techniques, and Osteoporosis.</p>	9.1.10 ongoing	

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W 127	<p>Continued From page 7</p> <p>At the time of the incident, the facility failed to ensure the required supervision.</p> <p>2. The facility failed to ensure staff provided transfer assistance in accordance with Client #1's established needs.</p> <p>Review of the facility's investigation report dated July 29, 2010, on August 4, 2010, at approximately 2:00 p.m. revealed that during the incident involving Client #1 on July 27, 2010, Staff #1 provided Client #1 with transfer assistance on three separate occasions. Staff #1 was noted to provide Client #1 transfer assistance without the benefit of any additional person. According to the investigation report, Staff #1 provided transfer assistance as detailed below:</p> <p>Staff #1 transferred Client #1 "from bed to shower chair..."</p> <p>Staff #1 picked Client #1 "up off the floor and set her on the shower chair" after the fall.</p> <p>Staff #1 transferred Client #1 "from shower chair to bed."</p> <p>Continued review of the investigation report revealed that Staff #1 had knowledge of the fact that Client #1 required the transfer assistance of two people. This was further verified through the review of Client #1's physical therapy assessment dated July 21, 2009 on August 4, 2010, at approximately 2:30 p.m. According to the assessment, "she transfers with maximum assistance of two people. The transfer sling is in place." The assessment further detailed, "Do not transfer [Client #1] using her upper extremities. Do not move her by pulling on her upper extremities."</p>	W 127	<p>Home Managers will post potential for fall risks to ensure further alert staff of potential for falls.</p> <p>The staff schedules were modified to ensure that at least five people are on duty between 6:00am-6:30am during the critical times when people are being transferred from the bed to the chairs. Staff deployment continues to be reviewed and modified to ensure more even distribution of tasks.</p>	
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W 127	<p>Continued From page 8</p> <p>Review of Client #1's Health Management Care Plan (HMCP) dated August 10, 2009, on August 4, 2010 at approximately 4:18 p.m. revealed a risk area or specific concern related to Client #1 involved osteoporosis and a potential for fractures. The HCMP further document that risk management procedures included adherence to "recommended transfer techniques only." At the time of the survey, the facility failed to ensure Client #1 was provided with transfer supports in accordance with Client #1's needs.</p> <p>3. The facility failed to ensure recommendations made as a result of the aforementioned investigation were implemented. Additionally, the facility failed to implement systems to make certain staff were sufficiently trained to ensure client safety.</p> <p>Review of the facility's investigation report dated July 29, 2010, on August 4, 2010, at approximately 2:00 p.m. revealed recommendations to address the incident including a corrective action for responsible staff person for not following transfer protocol as stated in the Physical Therapy Evaluation. According to interview with the House Manager and Qualified Mental Retardation Professional on August 4, 2010, the corrective action was to suspend Staff #1 immediately from duty. At the time of the investigation, Staff #1 continued to be on duty without suspension. Additionally, the facility failed to provide evidence that Staff #1 was provided with any in-service training to ensure clients were supervised in accordance with their needs.</p> <p>The findings of the investigation revealed the facility's failure to provide necessary supervision and support to Client #1 and its failure to</p>	W 127	<p><u>W127</u></p> <p>The Home Manager forwarded recommendation for disciplinary action on behalf of the employee for violating policies and procedures which was received by the DRS on the day of the of the survey. Further additional training and systems changes were under review and discussion at the time of the survey. Initial training was completed on the day of the incident by the Home Manager following the incident to include the staff person involved in the incident.</p>	9/1/10

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W 127	Continued From page 9 implement systems to prevent further potential harm posed likely harm to the clients residing in the facility. The Facility Coordinator (FC) and the Qualified Mental Retardation Professional (QMRP) were notified that an immediate jeopardy existed on August 4, 2010, at approximately 4:28 P.M. Prior to exiting the facility on August 4, 2010, the facility developed a plan of correction to lift the jeopardy that consisted of the following: <ul style="list-style-type: none"> Staff #1 will immediately be removed from all customer contact as of August 4, 2010; The QMRP and Facility Coordinator will conduct immediate staff in-service on safety and procedures for the shower area; Additional in-service will be conducted on the shower protocol; In-service will be conducted on policies and procedures in general safety of customers and not leaving them unattended during shower time; Immediate in-service on staff supervision and remaining in any area where individuals are present at all times. 	W 127	W149 This Standard will be met as evidenced by: The governing body found no pervasive patterns of serious or repeated incidents of abuse or neglect. The governing body has policies and procedures to protect the health and safety of the people served. The policies and procedures related to abuse and neglect are clearly defined. The category of serious reportable being judged based on the significance or severity of the incident. The incident Management policy has been reviewed and changes recommended to provide greater detail of the investigation review by the Administrator/designee. The policy prohibits mistreatment, neglect and abuse of the people from	
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 the interview and record review, the facility failed to develop and/or implement policies and procedures to make certain abuse, neglect or mistreatment was prohibited, failed to develop policies and procedures to prevent abuse and	W 149		9.8.10 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/04/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
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W 149	<p>Continued From page 10</p> <p>neglect and failed to ensure that systems were designed and implemented to make certain clients were not subjected to actual or potential neglect and/or physical injury for eight of eight clients residing in the facility. (Clients #1, #2, #3, #4 #5, #6, #7, and #8)</p> <p>The findings include:</p> <p>1. The facility failed to develop and implement a comprehensive incident management policy.</p> <p>(Cross Refer W127) On July 27, 2010, Health Regulations and Licensing Administration was notified via voicemail of an unusual incident report involving Client #1. According to the incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Continued review of the report revealed the incident was categorized as a reportable physical injury.</p> <p>Review of the corresponding investigation report (dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m. revealed the Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the incident was preventable. Review of Client #1's physical therapy assessment dated July 21, 2009, on August 4, 2010, at approximately 2:30 p.m. specified that Client #1 required supervision when seated in a chair with arms. It should be noted that observation of the shower chair used by Client #1 during the time of the incident on August 4, 2010, at approximately 5:45 p.m., revealed that it was a two arm shower chair. On August 4, 2010, at 4:15 p.m., the Facility</p>	W 149	<p>W149, continued...</p> <p>mistreatment, neglect and abuse of the people from mistreatment, neglect and abuse. In the interim of policy approval, an Incident Protocol will be implemented to ensure that all incidents are reported immediately to the administrator and suspicious or alleged allegations of abuse & neglect are further evaluated by an objective party.</p> <p>IDI employs a full time Incident Management Coordinator continues to monitor, track, evaluate and investigate incidents. The Incident Management Coordinator also monitors and tracks systemic patterns and provides recommendation for corrective actions as needed.</p>	
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W 149	<p>Continued From page 11</p> <p>Coordinator was interviewed and the facility's incident management policy was requested. The policy that was provided documented the definition of neglect and indicated that the "lack of attention to physical needs of an individual, including personal care, hygiene, meals or appropriate nutrition, shelter, and safety," constituted neglect. Continued review of the policy, however, failed to provide specific and detailed information regarding the necessary actions to be taken should an allegation of neglect be identified.</p> <p>2. The facility failed to ensure policies and procedures were implemented and developed to ensure client safety and provide information on necessary supervision supports required for each client.</p> <p>(Cross Refer W127) According to an incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report (dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m. revealed the Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the incident was preventable.</p> <p>Review of the corresponding investigation report dated July 29, 2010, on August 4, 2010, at approximately 2:00 p.m. revealed Staff #1 provided Client #1 with transfer assistance on three separate occasions. Staff #1 was noted to provide Client #1 transfer assistance without the benefit of any additional person. Continued review of the investigation report revealed that Staff #1 had knowledge of the fact that Client #1 required the transfer assistance of two people.</p>	W 149	<p>W149. _____</p> <p>The investigative findings concluded that the person sustained injury after falling from a shower chair. The injury sustained by the person was abrasion, closed head contusion. The injury was described by nurse as a bump. No other side effects observed. Categorized as a reportable due to severity of the injury. The person was assessed at the emergency room treated and released. This is also consistent with reportable category incident no x-ray or ct scan was necessary. The employee reported that she lifted and transferred the person without the supports of another staff. This action however, did not cause injury to the person.</p>	

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W 149	<p>Continued From page 12</p> <p>This was further verified through the review of Client #1's physical therapy assessment dated July 21, 2009 on August 4, 2010, at approximately 2:30 p.m. According to the assessment, "she transfers with maximum assistance of two people."</p> <p>Furthermore, interview with the Qualified Mental Retardation Professional (QMRP) on August 4, 2010, at approximately 4:41 p.m. revealed that Staff #1 should not have left Client #1 unsupervised while on the toilet. This information was verified through review of Client #1's physical therapy assessment dated July 21, 2009, on August 4, 2010, at approximately 2:30 p.m. The assessment documented that Client #1 "can sit in a chair with arms or recliner with supervision." Additional interview with the QMRP was conducted to ascertain information regarding any documentation that outlined the necessary supervision supports required for each individual. At the time of the investigation's conclusion, no evidence was provided that outlined the required supports. Moreover, there was no evidence that training was conducted to ensure and remind staff of the required supervision for each client.</p> <p>3. The facility failed to ensure policies and procedures were developed and implemented to prohibit abuse/neglect while an investigation was conducted.</p> <p>(Cross refer W155 and above) According to an incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report (dated July 29, 2010) on August 4, 2010, at approximately 2:00</p>	W 149	<p><u>W 149. continued...</u></p> <p>Changes have occurred in deployment of staff.</p> <p>Adaptive equipment continues to be checked on a weekly basis to ensure that it is maintained in good condition and in good repair. Staff are required to report all concerns immediately. The QMRP/Coordinator will conduct additional training as warranted.</p> <p>2. Cross reference response to W127</p> <p>3. Cross reference response to W155</p> <p>4. Cross reference response to W127, & W322.</p>	

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W 149	Continued From page 13 p.n.) revealed the Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the incident was preventable. Interview with the QMRP and additional review of the investigation report indicated that staff was negligent in providing the necessary supervision to Client #1 during the time of the incident. This investigation report further documented recommendations that included corrective actions for responsible staff person that failed to follow the transfer protocol and the sitting protocol as stated in Physical Therapy Evaluation. Interview with the Facility Coordinator and Qualified Mental Retardation Professional on August 4, 2010, revealed that the corrective action was to immediately place Staff #1 on administrative leave. Continued interview with the House Manager revealed that at the time of the investigation, Staff #1 had not been removed from direct care duty. Furthermore, there was no evidence Staff #1 had been restrained on necessary supervision supports required for Client #1.	W 149		
W 154	4. (Cross Refer W127, W322, and above) The facility failed to ensure initial first aid procedures had been implemented/developed to protect Client #1 after a falling incident and ensure Client #1 was not subjected to potential further harm. 5. The facility failed to ensure policies and procedures were implemented/developed to ensure required investigations were thorough. (See W154)	W 154	W154 This Standard will be met as evidenced by: The facility conducted immediate investigation into the injury sustained by client #1. Also, reference 000 verified that the incident was reported in accordance to state law through established procedures. There has been no evidence to support that reported incidents have pattern of reduction of an allegation exist. In cases, where abuse or neglect is suspected actions consistently have been taken to ensure that corrective actions has been taken up to and including termination of employment.	9.9.10 mgp/nc
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS			

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W 154	<p>Continued From page 14</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation into an incident that involved Client #1 falling, as a result of insufficient supervision.</p> <p>The findings include:</p> <p>[Cross refer to W149]. On July 27, 2010, Health Regulations and Licensing Administration was notified via voicemail of an unusual incident report involving Client #1. According to the incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report (dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m., revealed Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the incident was preventable. Continued review of the investigation failed to provide information regarding the following:</p> <ol style="list-style-type: none"> 1. The investigator failed to interview all staff persons present at the time of the incident. The investigator interviewed Staff #1 however there was no evidence that LPN #1 and Staff #2 had been interviewed to ascertain any pertinent information regarding the incident. 2. The investigative report reflected "corrective action for the responsible person not following transfer protocol," however, the corrective action 	W 154	<p>W154, Continued...</p> <p>Investigation findings confirmed that staff #1 failed to adhere to transfer protocols; this action did not lead to the injury sustained by client #1. Investigative findings concluded that client #1 sustained injury from "falling" possibly sliding out of the chair. Staff # 1 violated policy and procedures and corrective actions were recommended in response to her actions. Staff #1 has been employed with the company since December 2003 and did not have any pattern of policy violations, been involved in any allegations/incidents involving the people served, staff to staff incidents or any other situations that might cause alarm.</p>	<p>9/8/10 ongoing</p>	

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 4984 ASTOR PLACE, SE WASHINGTON, DC 20019
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W 154	Continued From page 15 was not clarified in the report. When asked about the specifics of what the "corrective action" was, the Facility Coordinator (FC) on August 4, 2010 at 4:40 p.m. revealed that it meant Staff #1 was to be placed on administrative leave. Further interview with the FC revealed that Staff #1 had been on duty since the incident and had worked five shifts over a course of eight days after the recommendation for corrective action was documented.	W 154	W154, continued... Incident Management Coordinator/QMRP has conducted additional training on abuse & neglect. QMRP/Home Manger continue to monitor staff and provide feedback and direction as needed.	
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	3. Client #1 has a diagnosis of seizures, osteoporosis and has the potential for fractures and falls. The investigator determined Staff #1 was negligent in providing the appropriate transfer assistance and failed to recognize the need for immediate assessment prior to moving the client. The investigator documented " Staff #1 should not have picked up Client #1 from the floor by self and without the nurse first examining the (Client #1) due to her diagnosis of Osteoporosis and potential for fractures." Further review of the investigation revealed Client #1 was left unattended and there was the possibility that the shower chair belt was not secured around Client #1's waist. The investigation further documented that the incident was preventable. There was no evidence the investigator based on his/her conclusions determined if the staff's failure substantiated or unsubstantiated neglect.		DRS reviewed and discussed Incident Management Protocol addresses interviewing of staff, corrective actions, conclusions of investigation. DRS will continue to monitor and review incident investigation reports as outlined and provide feedback and direction as needed.	
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W 155	481.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by Based on interview and record review the facility	W 155	W155 This Standard will be met as evidenced by: Reference responses to W154, W127 and W149	98.10 ongoing
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W 155	Continued From page 17 work on August 4, 2010 and had worked since the incident occurred, although not specifically assigned to Client #1. The FC revealed that at the time of the investigation, Staff #1 had not been removed from direct care duty. It should be noted that interview with FC on August 4, 2010 at approximately 4:03 p.m. revealed all the clients in the facility were at risk for falls and required supervision.	W 155			
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator or designated representative in accordance with State Law within five working days of the incident for Client #1 the focus of the investigation and two of seven clients residing in the facility (Clients #2 and #3). The findings include: 1. (Cross Refer W149) On July 27, 2010, Health Regulations and Licensing Administration was notified via voicemail of an unusual incident report involving Client #1. According to the incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report	W 156	W156 This Standard will be met as evidenced by: 1. Reference response to W149. 2. Incident Management Coordinator has been designated to review and evaluate all incidents and conduct investigations as warranted. Policy changes have been recommended to further include review by Director of Residential Services. Signed Investigations previously reviewed by the DRS have been filed in the home.	8.23.10 ingony	

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W 156	<p>Continued From page 18</p> <p>(dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m. revealed the Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the Incident was preventable. Client #1 was transported to the emergency room where she was evaluated, treated and released.</p> <p>The facility's internal investigation dated July 29, 2010, was reviewed on August 4, 2010. Interview with the Incident Management Coordinator (IMC) on August 4, 2010 at approximately 4:50 p.m. revealed that the administrator reviewed the investigation, however he acknowledged that there was no documented evidence to support his statement. At the time of the investigation, there was no evidence the administrator reviewed the results of the investigation.</p> <p>2. Review of an investigative report dated June 24 2010 on August 4, 2010, revealed an incident involving Client #2. According to the investigative report, the client was discovered with her right toe nail partially intact. The report failed to have documented evidence that the administrator or designee reviewed the results of the report. Interview with the Incident Management Coordinator (IMC) on August 4, 2010, at approximately 4:50 p.m. revealed that the administrator reviewed the investigation, but there was no documented evidence to support his statement.</p> <p>3. Review of an investigative report on August 4, 2010, dated May 5, 2010 involving Client #3 revealed that Client #3 was observed with a reddened area on her right knee about the size of a quarter. Further review of the investigative report revealed that the IMC reviewed the report</p>	W 156			

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W 156	Continued From page 19 on May 5, 2010. Interview with the IMC on August 4, 2010 revealed that he reviews the reports of other investigator. When queried to ascertain if he was considered the administrator or designee, he stated that he was not and acknowledged that the Director of Residential Services should have been the one to review the report.	W 156			
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, (See W159), failed to ensure continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently [See W189]; and failed to ensure that all staff working with the clients had been effectively trained on basic first aid skills necessary to make certain clients are not subjected to potential further harm. (See W342)	W 158	W158 This CONDITION will be met as evidenced by: Reference responses to W159, W189, and W342. Also reference responses to W122.	9.8.10 ongoing	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159			

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W 155	<p>Continued From page 16</p> <p>failed to provide evidence that Client #1 was protected from potential abuse and/or neglect while the investigation is in progress and failed to ensure the remaining seven clients were not placed at risk. (Clients #2, #3, #4, #5, #6, #7, and #8)</p> <p>The findings include:</p> <p>On July 27, 2010, Health Regulations and Licensing Administration was notified via voicemail of an unusual incident report involving Client #1. According to the incident report dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report (dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m. revealed the Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the incident was preventable. Interview with the QMRP and additional review of the investigation report indicated that staff was negligent in providing the necessary supervision to Client #1 during the time of the incident.</p> <p>Continued review of the investigation report documented recommendations that included corrective actions for the responsible staff person that failed to follow the transfer protocol and the sitting protocol as stated in Physical Therapy Evaluation. Interview with the Facility Coordinator (FC) and Qualified Mental Retardation Professional on August 4, 2010, revealed that the corrective action was to immediately place Staff #1 on administrative leave. The FC revealed at approximately 3:45 p.m. that Staff #1 was scheduled to report to</p>	W 155			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/04/2010
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019	
(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)	(X6) COMPLETION DATE
W 159	Continued From page 20 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for eight of eight clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8) The findings include: 1. The QMRP failed to ensure that the staff were provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. [See W159] 2. The QMRP to ensure that all staff working with the clients had been effectively trained on basic first aid skills necessary to make certain clients are not subjected to potential further harm. [See W342]	W 159	W189 This Standard will be met as evidenced by: The staff assigned to the home will receive training in the following areas to include but not limited to; Additional training will be coordinated and conducted for all staff to include all persons residing at this location. Osteoporosis Client Rights/Sensitivity Accidents/falls Transfer/lifting Reporting equipment status/malfunctions HMCP Mealtime Protocols Adaptive Equipment/maintaining in good condition, reporting concerns Nutrition/Speech food textures diet Securing proper hygiene items prior to implementing bathing/hygiene routines. Individual Shower/bathing protocols Head Injuries/ What to Watch for Signs/symptoms	9.8.10 original
W 189	481.430(e)(1) STAFF TRAINING PROGRAM This 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 review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include:	W 189		

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W 189	Continued From page 21 (Cross Refer W149) According to an incident reprint dated July 27, 2010 and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report dated July 29, 2010, on August 4, 2010, at approximately 2:00 p.m. revealed Staff #1 provided Client #1 with transfer assistance on three separate occasions. Staff #1 was noted to provide Client #1 transfer assistance without the benefit of any additional person. Continued review of the investigation report revealed that Staff #1 had knowledge of the fact that Client #1 required the transfer assistance of two people. This was further verified through the review of Client #1's physical therapy assessment dated July 21, 2009 on August 4, 2010, at approximately 2:30 p.m. According to the assessment, "she transfers with maximum assistance of two people." Review of the facility's training documentation on August 4, 2010, at approximately 3:30 p.m. revealed that at all staff received training on "Transfer/Safety" on November 2, 2009, and June 23 2010. It should be noted however, that review of the participants in the training failed to provide evidence that Staff #1 had been in attendance for either training.	W 189	QMRP/Home Manager will receive training on staff competency, monitoring and taking actions to address, staff deployment, tracking training, monitoring staff activities at critical periods of the day and night. Cross reference response to W149.	9-8-10 ongoing
W 322	463.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 322		

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WV 322	Continued From page 22 failed to ensure general and preventive care for one of one client (Clients #1) included in the sample. The finding includes: (Cross Refer W127) The facility failed to ensure initial first aid procedures had been implemented to protect Client #1 after a falling incident and ensure Client #1 was not subjected to potential further harm. On July 27, 2010, Health Regulations and Licensing Administration was notified via voicemail of an unusual incident involving Client #1. According to the incident report dated July 27, 2010, and information received from the provider agency, Client #1 sustained a closed head injury - contusion, to her right forehead. Review of the corresponding investigation report (dated July 29, 2010) on August 4, 2010, at approximately 2:00 p.m. revealed the Client #1's injury was sustained as a result of "falling while left unattended." Additionally, the investigation indicated that the incident was preventable. The investigation additionally documented that Staff #1 picked Client #1 up from the floor by herself prior to being assessed for any injuries. Further review of the investigation revealed that Staff #1 "should not have picked up Client #1 from the floor by self and without the nurse first examining Client #1 due to her diagnosis of Osteoporosis and potential for fractures." At the time of the investigation, the facility failed to ensure Client #1's injury was assessed by the nurse prior to being moved.	W 322	W322 This Standard will be met as evidenced by: Cross reference response to W127. Client #1 did not sustain injury related to Osteoporosis. The staff's failure to lift using two person transfers did not cause injury to the person. Client #1 was assessed following the occurrence of the incident. The home has 24 hour nursing coverage. The nurse on duty responded immediately and provided first aid to the person and completed notifications. Reference W189 all staff will be scheduled to attend first aid class on 9.15 and 9.23.10 to further ensure compliance with this standard.		
W 342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with	W 342			

8.5.10
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W 342	<p>Continued From page 23</p> <p>other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of the records, the facility's nursing services failed to ensure that all staff working with the clients had been effectively trained on basic first aid skills necessary to make certain clients are not subjected to potential further harm, for one of one client. (Client #1)</p> <p>The findings include:</p> <p>(Cross Refer W322). The facility failed to provide evidence that staff were effectively trained on basic first aid skills to address and ensure initial assessment of a client after a fall. Interview with the Registered Nurse and Nurse Practitioner on August 4, 2010, revealed that they were not sure if staff had received training to address the issue of not moving clients after falls prior to a nurse assessing the client. Review of the training manuals on August 4, 2010 at approximately 4:00 p.m. additionally failed to provide evidence that the staff had been trained in this area.</p>	W 342	<p>W342</p> <p>This Standard will be met as evidenced by:</p> <p>Cross reference response to W322.</p> <p>The nurse on duty was notified following the incident. She conducted an assessment and notified the NP, PCP and RN of her findings. The person continued to be monitored for signs and symptoms such as change in mental status, swollen area and pain.</p> <p>A Fall/Head Injury protocol has been established for all staff including basic standards of practice to be implemented if a person sustains a head injury or fall. Governing body shall review and update policies and procedures on Falls/head injury. In the interim the Protocol shall be utilized. At no</p>	<p>9.9.10 ongoing</p>
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WV 342	<p>Continued From page 23</p> <p>other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of the records, the facility's nursing services failed to ensure that all staff working with the clients had been effectively trained on basic first aid skills necessary to make certain clients are not subjected to potential further harm, for one of one client (Client #1)</p> <p>The findings include:</p> <p>(Cross-Refer W322). The facility failed to provide evidence that staff were effectively trained on basic first aid skills to address and ensure initial assessment of a client after a fall. Interview with the Registered Nurse and Nurse Practitioner on August 4, 2010, revealed that they were not sure if staff had received training to address the issue of not moving clients after falls prior to a nurse assessing the client. Review of the training manuals on August 4, 2010 at approximately 4:00 p.m. additionally failed to provide evidence that the staff had been trained in this area.</p>	WV 342	<p>W342, continued...</p> <p>time should the person be moved or picked up. The nurse must immediately assess the person for injury and effectively implement basic first aid practices.</p> <p>The NP will conduct additional training to include but not limited to: signs and symptoms of illness, basic first aid practices for falls and accidents to ensure that the people are not subjected to potential further harm. If at any time it has been determined that a staff person failed to adhere to the procedures set-forth corrective actions will be taken.</p>	