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FEB - 6 2008

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

PRINTED: 01/16/2008
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2008
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS A recertification survey was conducted from January 7, 2008 through January 10, 2008. The survey was initiated using the fundamental survey process; however, due to the deficient practice in the Condition of Client Protections, the survey process was extended to a full survey. A random sample of two clients was selected from a resident population of four males with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with residential, day program, nursing and administrative staff. Review of records, including review of unusual incidents and investigation reports was also conducted. The facility was deficit in the Conditions of Participation in Governing Body and Management and Health Care Services.	W 000		2008 FEB - 6 P 1:26 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2/6/08
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	<u>W 102</u> ILS HAS AND WILL CONTINUE TO ENSURE THAT THE GOVERNING BODY AND MANAGEMNT REQUIREMENTS ARE MET BY CONTINUING TO IMPLEMENT EXISTING POLICIES TO ENSURE ADEQUATE AND APPROPRIATE HEALTHCARE	2/6/08
W 104	This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility [Cross Refer to W104]. The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the Condition of Health Care. [Cross Refer to W318]	W 104	<u>W 104</u> ILS WILL DEMONSTRATED AT EVERY LEVEL AND ENSURE COMPLIANCE WITH THE CONDITION OF HEALTH CARE VIA ON GOING STAFF TRAINING IMPLEMENTATION OF ADEQUATE AND APPROPRIATE POLICIES AND PROCEDURES, PRESENT MEASURESTO ENSURE THE APPROPRIATE AND ADEQUATE DELIVERY OF	
W 104	483.410(a)(1) GOVERNING BODY	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE **2/5/08**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	<p>Continued From page 1</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 observations, staff interviews, and record reviews the governing body failed to ensure that the facility exercised general policy, and operating direction over the facility.</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Cross Refer to W 322.1. The Governing Body failed to establish and implement policies and procedures to ensure that the medical consultants recommendations were addressed in a timely manner by the Primary Care Physician for one of two clients in the sample. 2. Cross Refer to W 322.2. The Governing Body failed to ensure that medical services provided a complete diet order on the physician's order sheet (POS) for one of two clients in the sample. 3. Cross Refer to W331. The governing body failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of one of two clients in the sample. 4. Cross Refer to W338. The governing body failed to ensure that the facility's nursing staff provided timely follow-up on referrals in accordance with the needs of one of one of two clients in the sample. 4. Cross Refer to W368. The governing body failed to ensure that the facility's nursing staff administered medications in compliance with the 	W 104	<p>HEALTH CARE TO ALL INDIVIDUALS THAT SERVICES ARE PROVIDED.</p> <p>ILS CONTINUE TO EXERCISE GENERAL AND EFFECTIVE IMPLENTATION OF POLICIES, BUDGET AND OPERATIONAL DIRECTION OVER ITS FACILITIES. ILS GOVERNING BODY HAS ENSURED THAT RECOMMENDATIONSAND HEALTH CARE HAVE BEEN DELIVERED IN AN APPROPRIATE AND TIMELY MANNER. IN SITUATIONS WERE THEIR IDENTIFIED EXTENUATING CIRCUMSTANCE WERE DOCUMENTED. GOVERNING BODY HAS TAKEN EXTEREME MEASURES TO ATTEMPT TO RECONCILE THIS MATTER.THE CURRENT POLICIES AND PROCEDURES OF ILS HAS AFFORD VERY FEW INSTANCES WHERE THERE WAS NOT TIMELY FOLLOW UP OF RECOMMENDATIONS.</p> <p>IN CASES WHERE THE RECOMMENDATION WAS UNABLE TO BE COMPLETED IN A TIMELY MANNER. ILS CLEARLY DOCUMENTS IT'S STEPS TAKEN IN AN ATTEMPT TO ADDRESS ALL MATTERS INVOLVED. ILS PROVIDE ADDITIONAL OBJECTIVE MONITORING TO FURTHER DECREASE THE POTENTIAL DELAY IN FOLLOWS UP.</p>	2/6/08

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W 104	Continued From page 2	W 104	<u>W104 CONTINUES</u>	2/6/08
W 120	physician's orders for one of two clients in the sample. 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that outside services met the needs for one of the two clients in the sample. (Client #1). The findings include: Observations conducted at the day program on January 8, 2008 at starting at 9:15 AM revealed Client #1's 1:1 staff had removed his adaptive helmet while sitting at the table with his peers. Further observations at 9:20 AM revealed Client #1 was transported to the water fountain by his 1:1 staff. The 1:1 staff was observed to support Client #1 with ambulating by keeping his overhand at his pelvis/trunk area, and by keeping his body close to the client's without interfering with his movements. Interview with the day program lead counselor at approximately 9:40 AM revealed that he was aware of the "new helmet and ambulation protocol" for Client #1, but had not received training on protocol. Further interview with the day program Case Manager at 9:51 AM revealed that they have not received a copy of the Client #1's new protocols. Review of Client #1's records revealed no evidence of the Helmet and Ambulation Protocols located in the records.	W 120	1.SEE W322.1 2.SEE W322.2 3.SEE W331 4. SEE W338 5. SEE 368 <u>W 120</u> ILS QMRP AND NURSING STAFF WILL ENSURE THAT ADEQUATE TRAINING IS COMPLETED AT DAY PROGRAMS AND ALL PROTOCOLS FOR NEW ADAPTIVE EQUIPMENT IS PROVIDED WITHIN APPROPRIATE TIME. ILS WILL ENSURE THIS PROCESS BY HAVING NURSING COORDINATOR REVIEW RECOMMENDATION MONTHLY.	2/6/08

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W 120	Continued From page 3 Interview with the acting Qualified Mental Retardation Professional (QMRP)/Program Manager on the same day at approximately 12:00 PM revealed that she had just faxed over the new "Helmet and Ambulation Protocols" dated December 24, 2007 over to Client #1's day program. Further interview with the QMRP acknowledges that the day program staff have not received training on the new protocols.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the two clients in the sample. (Client #2) The finding includes: Client #2 was observed during the evening medication pass on January 7, 2008, at approximately 4:09 PM being administered Chlorpromazine 150 mg by mouth. Interview with the Licensed Practical Nurse (LPN) on January 7, 2008 at approximately 4:15 PM revealed that Client #2 was prescribed the medication for behavior management. Review of the physician's order sheet (POS) dated December 1, 2007 on	W 124	<u>W 124</u> CLIENT #2 DOES NOT TAKE LISINOPRIL 5MG BY MOUTH DAILY FOR BEHAVIOUR MANAGEMENT. THIS MEDICATION IS USED FOR HIS BLOOD PRESSURE. ILS PROVIDES AND DISCUSS WITH CLIENT #2 MOTHER ABOUT ALL PSYCOTROPIC MEDICATIONS ON THERE USE AND SIDE EFFECTS AT ALL ISP MEETINGS. THESE MEDICATIONS WERE DISCUSSED AT HIS ISP LAST YEAR AND WILL BE DISCUSSED AGAIN THIS YAER.AT CLIENT # 2 ISP IN MARCH 2008. IF THERE ARE CHANGES DURING THE YEAR THE FAMILY IS NOTIFIED OF THOSE CHANGES. ILS WILL ENSURE FAMILIES ARE VERY AWARE AND DISCUSS POTENTIAL OF SIDE EFFECTS TO THEM AT THE ANNUAL ISP.	2/6/08

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W 124	Continued From page 4 January 9, 2008 at approximately 11:15 AM revealed that Client #2 has diagnoses of Intermittent Explosive Disorder (IED) and Schizophrenia; Chronic Undifferentiated Type and was prescribed Chlorpromazine 150 mg by mouth twice a day and Lithium 150 mg every day for seven days. Lisinopril 5 mg. by mouth every day for behavior management. Interview with the Program Manager on January 8, 2007 at approximately 3:00 PM revealed that Client #2's mother was very involved in his life but is not the client's legal guardian. Review of Client #2's, psychological assessment dated March 19, 2007 on January 9, 2008 at approximately 11:18 AM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	CLIENT #2'S MOTHER IS NOW THE SURROGATE DECISION MAKER FOR HER SON AND ALL PAPERWORK HAS BEEN COMPLETED. (SEE ATTACHED). CLIENT #1 HAS A LEGAL GUARDIAN AND CLIENT #4 ALSO HAS A SURROGATE DECISION MAKER. ILS CONTINUE TO AWAIT A GUARDIAN TO BE ASSIGNED BY THE COURT FOR CLIENT #3. ILS WILL CONTINUE TO FOLLOW UP WITH THE ATTEMPT TO OBTAIN A LEGAL GUARDIAN.	2/6/08
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. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for two of two clients in the sample. (Client #1 and Client #2)	W 159	<u>W 159</u> (1). ILS WILL ENSURE THAT ALL DAY PROGRAMS AS WELL AS RELEVANT PERSONS ARE TRAINED ON ALL MEDICAL PROTOCOLS. ILS WILL CONTINUE TO USE THE LPN COORDINATOR AT EACH FACILITY ALONG WITH THE QMRP TO ADDRESS THIS ISSUE AND TO MAINTAIN COMPLIANCE. (2). ILS QMRP WILL RECEIVE TRAINING ON APPROPRIATE DATA COLLECTION AS WELL AS USE QA SYSTEMS TO ENSURE FOLLOW UP. (3). ILS QMRP WILL RECEIVE TRAINING ON FOLLOW UP AND IMPLEMENTATION OF CONSULTANT	2/6/08

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W 159	Continued From page 5 The finding includes: 1. Cross refer to W120. The QMRP failed to ensure that Client #1's day program was trained and received a copy of his new "Helmet and Ambulation Protocol." 2. Cross refer to W252. The QMRP failed to ensure that data had been collected in accordance with the IPPs for Client #1. 3. The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the Physical Therapist's (PT's) recommendation for Client # 2 was addressed as evidenced by: Observation of Client #2 at the day program on January 8, 2008 at approximately 10:30 AM-12:00 PM revealed that the client sat in chairs and ambulated in a forward bent over manner. Review of Client #2's physician's order sheet (POS) dated December 1, 2007 on January 8, 2008 at approximately 2:11 PM revealed that the client has a diagnosis of kyphoscoliosis. Review of the PT assessment dated March 21, 2007 on January 9, 2008 at approximately 11:36 AM revealed that Client #2 was recommended to be considered for a scapular harness to promote more upright posture.	W 159	RECOMMENDATION AS QA SYSTEMS TO ENSURE COMPLIANCE. HOWEVER AS IT RELATES TO THIS PARTICULAR RECOMMENDATION FOR CLIENT #2. THIS RECOMMENDATION WAS REVIEWED AT HIS ISP MEETING IN MARCH 2007 AND IT WAS DETERMINED THAT THIS RECOMMENDATION WAS NOT APPROPRIATE AND CLIENT #2 COULD NOT TOLERATE IT. THEREFORE IT WAS NOT ADDED TO THE RECOMMENDATION ON THE CURRENT ISP AND WAS FURTHER DOCUMENTED BY THE BEHAVIOURAL SPECIALISTS AND ALL RECORDS, WHICH WERE AVAILBLE AT THE TIME OF THE SURVEY.	2/6/08 2/6/08	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by:	W 192			

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W 192	<p>Continued From page 6</p> <p>Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four clients in the facility. (Clients #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>1. The Program Manager/acting Qualified Mental Retardation Professional (QMRP) failed to ensure that all staff had been effectively trained to implement emergency measures for four of four clients in the facility as evidenced by:</p> <p>Interview with the House Manager and QMRP on January 9, 2008 at approximately 1:15 PM revealed that all staff was not trained in CPR. Record review on January 9, 2008 at approximately 1:30 PM revealed that six (6) out of twelve direct care staff did not have current CPR certifications. Further review of the records revealed that two consultants (Registered Nurse and Licensed Practical Nurse) were without current CPR certification. There was no documented evidence that all direct care staff including consultants had CPR training and current CPR certifications.</p> <p>2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for four of four clients in the facility as evidenced by:</p> <p>Interview with the House Manager on January 10, 2008 at approximately 8:47 AM revealed that all staff was not trained in First Aid. Record review on January 10, 2008 at approximately 9:00 AM revealed that six (6) out of twelve direct care staff did not have current First Aid certifications. Further review of the records revealed that one</p>	W 192	<p><u>W 192 (1&2).</u> ILS WILL ENSURE THAT ALL ILS STAFF ARE TRAINED IN FIRST AID AND CPR ILS WILL ALSO HAVE ITS HR/TRAINING COORDINATOR BECOMES CERTIFIED. CPR/FIRST AID INSTRUCTOR TO DECREASE THE DELAY IN HAVING STAFF TRAINED.</p>	2/6/08

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W 192	Continued From page 7	W 192		
W 252	<p>consultant (Registered Nurse) was without current First Aid certification. There was no documented evidence that all direct care staff including consultants had First Aid training and current First Aid certifications.</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was collected in the form and required frequency for one of two clients included in the sample. (Client #1)</p> <p>The findings include:</p> <p>The facility failed to ensure that data had been collected in accordance with the IPPs for Client #1, which was necessary for a functional assessment of the client's progress as evidenced below:</p> <p>1. Evening observations conducted on January 7, 2008 at approximately 4:37 PM revealed Client #1 went for a community walk with his 1:1 staff to identify survival signs. Further observations conducted at the day program on January 8, 2007 at approximately 9:33 AM revealed Client #1 identifying survival signs at 9:33 AM. (i.e. Do not touch, Do not enter, keep out, and exit signs). Interview with 1:1 staff on January 7, 2008 at approximately 6:21 PM revealed that Client #1</p>	W 252	<p><u>W 252 (1,2,3).</u> ILS WILL CONDUCT AN ON GOING TRAINING WITH STAFF ON DATA COLLECTION AND IMPLEMENTATION OF IPP GOALS. ILS QMRP WIL FURTHER ENSURE COMPLIANCE WITH DOCUMENTATION.</p>	2/6/08

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W 252	<p>Continued From page 8</p> <p>has a program to identify survival signs. Review of the client's Individual Program Plan (IPP) dated April 13, 2007 on January 8, 2008 at approximately 11:23 AM revealed a program objective which read "the client will discriminate (3) universal safety survival signs commonly found in the home, day program, and community environment with 60% accuracy per session for 3 consecutive months. Review of the data collection sheets on January 9, 2008 at 3:16 revealed no documentation for the days of 1/2/08, 9/3/07, 9/5, 9/12, 9/14, and 9/21. Interview with the QMRP on January 9, 2008 at approximately 3:32 PM acknowledged that the data was not being collected in accordance with the IPP.</p> <p>2. Observations conducted on January 8, 2008 at approximately 9:24 AM at the day program revealed Client #1 identifying monetary coins at the table with his 1:1 staff. Interview with 1:1 staff on January 8, 2008 at approximately 9:51 AM revealed that Client #1 has a program to identify coins. Review of the client's Individual Program Plan (IPP) dated April 13, 2007 on January 8, 2008 at approximately 11:25 AM revealed a program objective which read "the client will identify coins with 50% accuracy per session for three consecutive months. Review of the data collection sheets on January 9, 2008 at 3:14 PM revealed no documentation for the days of 10/10/07, 10/17, 10/24, 9/3/07, and 8/31/07. Interview with the QMRP on January 9, 2008 at approximately 3:30 PM acknowledged that the data was not being collected in accordance with the IPP.</p> <p>3. Further review of Client #1's IPP on January 8, 2008 at approximately 11:27 AM revealed and</p>	W 252		2/6/08

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W 252	Continued From page 9 objective which read "the client will use a personal talker in response to query for personal information with 80% accuracy per session for 3 consecutive months. Interview with the 1:1 staff on January 7, 2008 at approximately 6:21 PM revealed that Client #1 has a communication device that he speaks into to record and repeat his personal information. Review of the data collection sheets on January 9, 2008 at 3:14 PM revealed no documentation for the days of 8/31/07, 9/3/07, 10/16/07, and 10/31/07. Interview with the QMRP on January 9, 2008 at approximately 3:30 PM acknowledged that the data was not being collected in accordance with the IPP.	W 252		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record reviewed, the facility failed to effectively train staff to implement emergency measures [Cross Refer to W192]; failed to provide preventive and general health care services to meet the needs of the clients [Cross Refer to W322]; the facility failed to establish systems to provide health care monitoring and identify services that would ensure nursing services were provided in accordance with clients needs [Cross Refer to W331]; failed to ensure timely medical follow up failed to ensure health services were provided to meet the needs of the clients [Cross Refer to W338] and failed to ensure that medications were administered in accordance to physician's orders. [Cross Refer to W368]	W 318	<u>W 318</u> ILS WILL CONTINUE TO DEMONSTRATE APPROPRIATE AND ADEQUATE HEALTH CARE SERVICES IN THE FORM OF IMPLEMENTING OF HEALTH RELATED SERVICES, PREVENTIVE, MEDICINE AND FOLLOW UP.	2/6/08

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W 318	Continued From page 10	W 318		
W 322	<p>The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's medical services failed to address a recommendation made by a medical consultant for one of two clients in the sample (Client #2) and the facility failed to provide a complete diet order on the physician's order sheet (POS) for one of two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. Review of the nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11: 00 AM revealed that Client #2 had a diagnosis of stable chronic kidney disease; Stage 2, probably from lithium toxicity due to long standing use. Further review of the nephrology consult revealed a recommendation that Client #2's dosage of Lisinopril 5 mg. by mouth every day be increased to Lisinopril 10 mg. by mouth every day. Review of the Medication Administration Record (MAR) dated January, 2008 at approximately 4:25PM revealed that Client #2 was administered Lisinopril 5 mg. by mouth. Review of the physician's order sheet (POS) dated December 1, 2007on January 9, 2008 at approximately 11:10 AM revealed that</p>	W 322	<p><u>W 322</u></p> <p>ILS PCP DEMONSTRATED APPROPRIATE FOLLOW UP AND PREVENTIVE CARE FOR CLIENT #2. WHEN CLIENT #2LAB WORK WAS ABNORMAL, PCP IMMEDIATELY REFERED CLIENT #2 TO A NEPHROLOGIST OF WHICH HE PERSONALLY DID A FOLLOW UP WITH. WHEN CLIENT #2 RETURNED FROM THE CONSULT WITH THE NEPHROLOGIST, NURSE CALLED THE PCP AS WELL AS FAX THE CONSULT TO HIM. ON 12/19/07 UPON RETURN PHONECALL THE PCP STATED THAT HE WOULD ADDRESS THE RECOMMENDATION IN WRITING WHEN HE DID HIS MONTHLY VISIT TO THE HOME AS HE HAD ALREADY COMPLETED HIS PRIOR MONTHLY VISIT. THE RECOMMENDATION ON 01/10/08. ILS WILL CONTINUE TO DISCUSS AS A TEAM, WAYS TO IMPROVE FOLLOW UP AND DELIVERY OF HEALTHCARE SERVICES</p>	2/6/08

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W 322	<p>Continued From page 11</p> <p>Client #2 had a diagnosis of hypertension and was prescribed Lisinopril 5 mg. by mouth every day for blood pressure management. In an interview with the Licensed Practical Nurse (LPN) on January 9, 2008 at approximately 2:00 PM it was acknowledged that Client #2 was administered Lisinopril 5 mg. by mouth every day. Further interview revealed that the Primary Care Physican (PCP) was made aware of the nephrologist 's recommendation. Review of a nursing progress note dated December 18, 2007 on January 9, 2008 at approximately 2:15 PM revealed " [Client #2] visted the nephrologist yesterday as scheduled due to abn. [abnormal] renal results per PCP order, MD notified of all recommendation[s] via voice mail and consult form with information faxed to him ...awaits return call." There was no documented evidence that the PCP addressed the nephrologist 's recommendation that Client #2 's Lisinopril be increased from 5mg. every day to 10mg every day.</p> <p>2. Observation at the day program during the lunch meal on January 8, 2008 at approximately 11:00 AM revealed that Client #2 was served a low fat, low cholesterol, no added salt (NAS) chopped diet. Interview with the direct care staff on January 8, 2007 at approximately 11:10 AM revealed that Client #2 was served a low fat, low cholesterol, no added salt (NAS) chopped diet because he had hypertension and high cholesterol. Review of the physician's order sheet (POS) dated December 1, 2007 on January 8, 2008 at approximately 2:11 PM revealed that Client #2 was on a low fat, low cholesterol chopped diet. Review of the Nutritional Assessment dated March 19, 2007 on January 9, 2008 at approximately 10:40 AM indicated that</p>	W 322	<p>(2). ILS CONTINUES TO ENSURE THAT CLIENT #2 DOES NOT GET ADDITIONAL SALT ADDED TO HIS DIET AS HE IS HYPERTENSIVE. HOWEVER, THIS RECOMMENDATION WAS NOT FORMALLY ACCEPTED BY THE PCP, THIS WAS HOWEVER A RECOMMENDATION BY THE NUTITIONIST AT HIS ISP IN 2007. AGAIN PCP DID NOT CHOOSE TO MAKE IT A FORMAL RECOMMENDATION #2 BLOOD PRESSURE HAS REMAINED STABLE. ILS WILL HAVE PCP REVIEW RECOMMENDATION FURTHER TO DETERMINE IF HE WOULD LIKE TO MAKE ANY CHANGE TO POS. FURTHER FOLLOW UP WITH NUTRITIONIST REVEALED THIS IS AN ERROR.</p>	2/6/08

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W 322	Continued From page 12 Client #2 was on a low fat, low cholesterol, no added salt (NAS) chopped diet. There was no documented evidence that the NAS retriction was included on the POS.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and Client #2) The findings include: 1. Cross Refer to W338. The facility's nursing staff failed to ensure timely follow-up on referrals in accordance with the needs of one of the two clients in the sample. 2. Cross Refer to W368. The facility's nursing staff failed to ensure that medications were given in compliance with the physician's orders for one of the two clients in the sample. 3. The facility's nursing staff failed to ensure that Client #2's psychiatrist was aware of his abnormal lithium level as evidenced by: Review of a laboratory study dated July 20, 2007 on January 8, 2008 at approximately 2:45 PM revealed a lithium level of 1.23 MEQ/L [reference range 0.60-1.20 MEQ/L]. Further review revealed a recommendation from the Primary Care Physician (PCP) that the lithium level of 1.23	W 331	W 331 (1). SEE W 338 (2). SEE 368 (3). THE ELEVATED LITHIUM LEVELS WERE DISCUSSED WITH BOTH PCP AND PSYCHIATRIST. LAB WORKS ARE REVIEWED AT ALL PSYHOTROPIC MEDICATION REVIEWS. THE ELEVATED LITHIUM LEVELS WERE DISCUSSD AT THE NEXT PSYHOTROPHIC REVIEW	2/6/08 2/6/08 2/6/08

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W 331	Continued From page 14 6. The facility's nursing staff failed to update Client #2's HMCP as evidenced by: a. Review of Client #2's HMCP dated January 7, 2007 on January 8, 2008 at approximately 2:00 PM revealed that the HMCP had not been updated to include the client's diagnosis of hypertension. Review of the physician's order sheet (POS) dated December 1, 2007 on January 9, 2008 at approximately 11:10 AM revealed that Client #2 had a diagnosis of hypertension and was prescribed Lisinopril 5 mg. by mouth every day for blood pressure management. In an interview with the LPN on January 9, 2008 at approximately 2:20 PM it was acknowledged that the HMCP had not been updated to include the Client #2's diagnosis of hypertension. There was no documented evidence that the HMCP had been updated after January 7, 2007 to include the diagnosis of hypertension. b. Review of Client #2's HMCP dated January 7, 2007 on January 8, 2008 at approximately 2:00 PM revealed that the HMCP had not been updated to include the client's diagnosis of osteoporosis. Review of the POS dated December 1, 2007 on January 9, 2008 at approximately 11:20 AM revealed that Client #2 had a diagnosis of osteoporosis and was prescribed Fosamax one tablet weekly. Review of the Bone Densitometry consult dated October 9, 2007, on January 8, 2008 at approximately 2:15PM revealed that Client #2 had osteoporosis of the lumbar spine and hip with a high risk for fractures. In an interview with the LPN on January 8, 2008 at approximately 2:25 PM it was acknowledged that the HMCP had not been updated to include the Client #2's diagnosis of osteoporosis. There was no documented	W 331	HMCP TO REFLECT IMPLEMENTATION OF THE NEED ADAPTIVE EQUIPMENT AS WELL AS THE APPROPRIATE PROTOCOLS. ILS HAS DEMONSTRATED TIMELY AND APPROPRIATE MEDICAL INTERVENTION TO ENSURE THE HEALTH AND SAFETY OF CLIENT #1. (6A). ILS WILL ENSURE THAT THE HMCP FOR ALL INDIVIDUALS IS REVIEWED AND UPDATED AS NEEDED. QA SYSTEMS WILL PROVIDE MONITARY OF THIS PROCESS. (6B). SEE 6A	2/6/08	2/6/08

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W 331	Continued From page 15	W 331		
W 338	<p>evidence that the HMCP had been updated after January 7, 2007 to include the diagnosis of osteoporosis.</p> <p>483.460(c)(3)(v) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure timely follow-up on referrals in accordance with the needs of one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. The facility's nursing services failed to ensure that Client #2's audiology appointment was conducted timely as evidenced below:</p> <p>Review of an audiology consult dated June 22, 2007 on January 8, 2008 at approximately 3:45 PM revealed a recommendation that the client return to the audiology clinic in one month for removal of cerumen. In an interview with the Licensed Practical Nurse (LPN) on January 8, 2008 at approximately 3:47 PM it was revealed that Client #2 did not go back to the audiology clinic until January 4, 2008. There was no documented evidence that the client returned for an audiology appointment in a timely manner.</p> <p>[Note: Review of the audiology consult dated January 4, 2008 on January 8, 2008 revealed that</p>	W 338	<p>W 338 (1). ALTHOUGH THE CONSULT INDICATED THAT CLIENT #2 TO RETURN IN ONE MONTH. THE LPN CONTACT THE AUDIOLOGY CLINIC AND INFORMED THE NURSE TO CALL BACK IN NOVEMBER FOR AN APPOINTMENT IN, WHICH WAS DONE AND JANUARY 4 DATE WAS GIVEN. CLIENT #2 DID RETURN ALL OF WHICH IS DOCUMENTED IN THE NURSING NOTES. HE WAS SEEN. HOWEVER A FULL EXAMINATION WAS NOT COMPLETED AND HE WAS REFERED BACK TO ENT.</p>	2/6/08

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W 338	<p>Continued From page 16</p> <p>Client #2 was uncooperative and was unable to be examined.]</p> <p>2. The facility's nursing services failed to ensure that Client #2's lithium levels were obtained in a timely manner as evidenced below:</p> <p>a. Review of the psychotropic medication review dated September 19, 2007 on January 8, 2008 at approximately 8:38 AM revealed a recommendation that Client #2 have a repeat lithium level. Interview with the LPN on January 9, 2007 at approximately 10:00AM revealed that Client #2 did go to the laboratory to have his lithium level drawn; however the hospital failed to draw the blood for the lithium level. Review of laboratory studies on January 9, 2008 at approximately 10:30AM revealed that there were no lithium levels available for the month of September in the medical record. There was no documented evidence that the client's lithium level was obtained as in a timely manner.</p> <p>b. Review of the psychotropic medication review dated October 19, 2007 on January 8, 2008 at approximately 9:00 AM revealed a recommendation that Client #2 have a repeat lithium level obtained "stat" [immediately]. Interview and record review with the LPN on January 9, 2007 at approximately 1:00PM revealed that Client #2 refused to have his lithium level drawn on October 18, 2007 and October 23, 2007. Further interview revealed that Client #2 was sent to the laboratory to did his lithium level obtained on October 26, 2006. Review of a nursing progress note dated November 30, 2007 on January 9, 2008 at approximately 1:15 PM revealed that the hospital had not drawn the lithium level on October 26, 2007. Review of a</p>	W 338	<p>(2A&B). ILS COMPLIED WITH THE RECOMMENDATIONS OF PCP. ILS NURSING SENT CLIENT #2 TO THE LAB TO HAVE HIS LITHIUM LEVELS DRAWN. HOWEVER THE HOSPITAL FAILED TO DRAW THEM. ILS NURSING ATTEMPTED TO SEND CLIENTS #2 BACK TO THE LAB ON TWO OCCASIONS OF WHICH HE REFUSED. ON THE THIRD TIME THE LABS WERE DRAWN. ILS NURSING WAITED ONE WEEK WHICH IS THE STANDARD PROTOCOL FOR THE RESULTS AND WAS INFORMED, THAT THE COMPUTERS WERE DOWN. SHE CALLED BACK THE FOLLOWING DAY WHEN SHE WAS ABLE TO SPEAK TO SOMEONE AND IT WAS INDICATED THAT THE LITHIUM LEVELS WERE NOT IN THE SYSTEMS. THE NURSE INFORMED THE LAB THAT THE PAPER WORK INDICATED THAT THE LITHIUM LEVELS WERE COMPLETED AND WAS SIGNED OFF BY THE LAB. SHE WAS DIRECTED TO THE</p>	2/6/08	

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W 338	Continued From page 18 10:30AM revealed that there were no available Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels documented since September 25, 2007. There was no documented evidence that the Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels were obtained or scheduled in a timely manner. 4. The facility's nursing services failed to ensure that Client #2's ANA level was obtained in a timely manner as evidenced below: Review of the physician's order sheet (POS) dated Auquest 23, 2007on January 9, 2008 at approximately 8:10 AM revealed that Client #2 was ordered an ANA [microalbumin urine] level to be obtained. Further review revealed a recommendation for Client #2 to be referred for a nephrology consult because of abnormal renal function tests. Review of the physician's progress note dated December 4, 2007on January 9, 2008 at approximately 11:07 AM revealed a recommendation that have an ANA [microalbumin urine] level obtained prior to his nephrology follow-up on December 17, 2007. In an interview with the LPN on January 10, 2008 at approximately 11:45AM it was acknowledged that the ANA levels had been drawn; however the hospital failed to send the facility the results of the ANA levels. Review of laboratory studies on January 9, 2008 at approximately 10:30AM revealed that there was no documented ANA levels available in the medical record. There was no documented evidence that the client's ANA levels were obtained in a timely manner.	W 338	(4). CLIENT #2 WAS SENT TO THE LAB TO HAVE LEVELS OBTAINED. AGAIN THE HOSPITAL FAILED TO COMPLETE LAB WORK. UPON DISCOVER, ILS SENT CLIENT #2 BACK TO THE LAB.ILS WILLCONDUCT TRAINING WITH NURSING TO FOLLOW UP WITH LABS TO ENSURE CORRECT LABS ARE DRAWN AND IF NOT TO DOCUMENT AND IMMEDIATELY SEND INDIVIDUAL BACK TO THE LAB.	2/6/08
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with	W 368		

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W 368	<p>Continued From page 19 the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Review of a nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11: 00AM revealed that Client #2 had a diagnosis of stable chronic kidney disease, Stage 2 probably from lithium toxicity due to long standing use. Further review recommended "need to consider other alternatives to lithium." Review of the psychotropic medication review dated December 19, 2007on January 9, 2008 at approximately 11:10 AM revealed a recommendation to decrease and discontinue lithium over three weeks. Review of the physician's order sheet (POS) dated December 19, 2007 on January 9, 2008 at approximately 11:30 AM revealed an order to administer Lithium 300mg twice a day, times seven days. Further review revealed an order to than administer Lithium 150mg twice a day, times seven days. Review of the Medication Administration Record (MAR) dated December 1, 2007 on January 9, 2008 at approximately 12:00 PM revealed that Client #2 was administered Lithium 300mg twice a day by mouth from December 19, 2007at 5:00 PM to December 26, 2007 at 5:00 PM. Further review revealed that Client #2 was also administered Lithium 150mg by mouth on December 26, 2007 at 5:00PM. In an interview with the Licensed Practical Nurse (LPN) on</p>	W 368	<p><u>W 368.</u> THE M.A.R CLEARLY DEMONSTRATE THAT THE ORDERS TO DECREASE THE LITHIUM LEVELS WAS BEEN FOLLOWED BY NURSING ON THE M.A.R. THE NURSE FAILED TO SKIP TWO SPACES ON THE MA.R BETWEEN THE DECREASE OF THE 300MG AND THE 150MG WHICH MAY APPEAR TO LOOK AS IF ON DAY 7 OF THE 300MG AND DAY 1 OF THE 150MG. THERE IS AN OVERLAP. IT WAS FURTHER EXPLAINED TO THE MONITOR THAT IT WAS NOT POSSIBLE FOR CLIENT #2 TO GET BOTH 300MG AND 150MG ON THE SAME DAY AS ALL THE 300MG TABS HAD TO BE USED BY THEN 150MG BEGAN. ILS WILL CONDUCT TRAINING WITH NURSING ON DOCUMENTATION AND M.A.R.</p>	2/6/08

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W 368	Continued From page 20 January 10, 2008 at approximately 11:30AM it was acknowledged that the documentation on the MAR revealed that Client #2, had recieved Lithium 300mg and Lithium 150 mg by mouth on December 26, 2007 at 5:00 PM. Further interview revealed that the LPN did not think that Client #2 actually was administered Lithium 450mg by mouth on December 26, 2007 at 5:00PM. There was no evidence that the medication prescribed by the physician was given in compliance with the physician's orders.	W 368		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Program Manager (PM)/Acting Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on January 7, 2008 at approximately 2:15 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM 3rd Shift 10 AM to 8 AM Weekends/Saturday and Sunday 1st 8 AM to 4 PM 2nd 4 PM to 12 AM	W 440	<u>W 440.</u> ILS WILL CONDUCT MANY FIRE DRILLS AND ENSURE ADHERENT TO ORGANIZATIONAL POLICIES.	2/6/08

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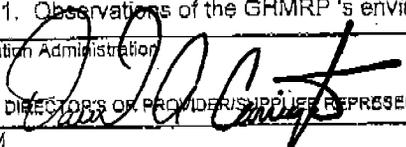
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W 440	Continued From page 21 3rd 12 AM to 8 AM Further interview with the PM/QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book from February 2007 to January 2008 revealed that the facility failed to hold simulated fire drills at least four times a year for each shift during the periods of February 2007 through April 2007. There was no evidence that fire drills were conducted quarterly on all shifts.	W 440		2/6/08	

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1 000	INITIAL COMMENTS A licensure survey was conducted from January 7, 2008 through January 10, 2008. The survey was initiated using the fundamental survey process; however, due to the deficient practice in the Condition of Client Protections, the survey process was extended. A random sample of two clients was selected from a resident population of four males with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with residential, day program, nursing and administrative staff. Review of records, including review of unusual incidents and investigation reports was also conducted. The facility was deficit in the Conditions of Participation in Governing Body and Management and Health Care Services.	1 000		
1 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: 1. Observations of the GHMRP 's environment	1 090	1090 THE FOOD SPILLAGE AT THE BOTTOM OF THE REFRIGERATOR HAS BEEN CLEANED. ILS WILL CONTINUE TO ENSURE THAT THE ENVIRONMENT IS MAINTAINED IN A SAFE CLEAN ORDERLY AND SANITARY MANNER	2/12/08

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Executive Director

(X5) DATE

2/12/08

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1 090	Continued From page 1 on January 10, 2008 revealed the refrigerator located in the basement was observed to have food spillage at the bottom. 2. The light fixture (Glass) in Resident #3's bedroom was observed broken.	1 090	<u>1090 (2)</u> ILS HAS PURCHASED A NEW LIGHT FIXTURE FOR RESIDENT #3'S BEDROOM. ILS WILL CONTINUE TO ENSURE THAT LIGHT FIXTURES ARE MAINTAINED IN GOOD WORKING CONDITION	2/12/08
1 135	3506.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Program Manager (PM)/Acting Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on January 7, 2008 at approximately 2:15 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 8 AM to 4 PM 2nd Shift 2 PM to 10 PM 3rd Shift 10 AM to 8 AM Weekends/Saturday and Sunday 1st 8 AM to 4 PM 2nd 4 PM to 12 AM 3rd 12 AM to 8 AM Further interview with the PM/QMRP revealed that the staff was required to conduct a drill once	1 135	<u>1135</u> SEE W440	2/12/08

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1135	Continued From page 2 per month on each shift. Review of the fire drill log book from February 2007 to January 2008 revealed that the facility failed to hold simulated fire drills at least four times a year for each shift during the periods of February 2007 through April 2007. There was no evidence that fire drills were conducted quarterly on all shifts.	1135		
1165	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on observations, staff interviews, and record reviews the governing body failed to ensure that the facility exercised general policy, and operating direction over the facility. The finding includes: 1. Cross Refer to W 322.1. The Governing Body failed to establish and implement policies and procedures to ensure that the medical consultants recommendations were addressed in a timely manner by the Primary Care Physician for one of two residents in the sample. 2. Cross Refer to W 322.2. The Governing Body failed to ensure that medical services provided a complete diet order on the physician's order sheet (POS) for one of two residents in the sample. 3. Cross Refer to W331. The governing body	1165	<u>1165</u> SEE W104	2/12/08

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1165	Continued From page 3 failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of two of two residents in the sample. 4. Cross Refer to W338. The governing body failed to ensure that the facility's nursing staff provided timely follow-up on referrals in accordance with the needs of one of one of two residents in the sample. 4. Cross Refer to W368. The governing body failed to ensure that the facility's nursing staff administered medications in compliance with the physician's orders for one of two residents in the sample.	1165			
1203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files conducted on January 9, 2008 at approximately 1:15 PM revealed the GHMRP failed to provide evidence of current signed job descriptions for of eight of twelvestaffs. (Staff #4, #5, #6, #7, #8, #12, #14, and 15)	1203	1203 ILS WILL ENSURE THAT CURRENT JOB DESCRIPTIONS FOR ALL EMPLOYEES ARE MADE AVAILABLE FOR REVIEW DURING SURVEYEEY. JOB DESCRIPTIONS ARE SIGNED BY ALL ILS STAFF BEFORE THEY CAN STAART WORK IN ILS.	2/12/08	
1206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and	1206			

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1206	Continued From page 4 annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings include: 1. Review of the personnel files conducted on January 9, 2008 at approximately 1:15 PM revealed the GHMRP failed to provide evidence of current current health certificates for five of twelve staffs. (S #7, #9, #12, #14, and #15). 2. Review of the personnel files conducted on January 10, 2008 at approximately 8:47 AM revealed the GHMRP failed to provide evidence of current current health certificates for one consultant. (C #3)	1206	1206 ILS WILL ENSURE THAT ALL STAFF HAVE A CURRENT HEALTH CERTIFICATE ON FILE. ILS WIL HAVE IT'S HUMAN RESOURCES REVIEW ALL EMPLOYEE FILES ON A MONTHLY BASIS TO ENSURE THAT ALL EMPLOYEES HAVE A CURRENT HEALTH CERTIFICATE.	2/12/08
1227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees.	1227	1227 SEE W192 (1&2)	2/12/08

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1227	Continued From page 5 The findings include: On January 9, 2008 at approximately 1:15 AM, review of personnel records/training records revealed that the following staffs and consultants was without current First Aid and CPR, or both. 1. Current CPR - S #4, #5, #11, #12 #13, and #14 2. First Aid - S #4, #5, #11, #12 #13, and #14 3. Current CPR - S #1 and #2 4. First Aid - S# 1and #2	1227		2/12/08
1401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, staff interview and record review, facility's medical services failed to address a recommendation made by a medical consultant for one of two residents in the sample (Resident #2) and the facility failed to provide a complete diet order on the physician's order sheet (POS) for one of two residents in the sample (Resident #2) and the facility's nursing services failed to ensure timely follow-up on referrals in accordance with the needs of one of the two residents in the sample. (Resident #2) The findings include:	1401	1401 SEE W22.1	2/12/08

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1401	Continued From page 6 1. Review of the nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11:00AM revealed that Resident #2 had a diagnosis of stable kidney disease Stage 2, probably from lithium toxicity due to long standing use. Further review of the nephrology consult recommended that Resident #2's dosage of Lisinopril 5 mg. by mouth every day be increased to Lisinopril 10 mg. by mouth every day. Review of the Medication Administration Record (MAR) dated January, 2008 at approximately 4:25PM revealed that Resident #2 was administered Lisinopril 5 mg. by mouth. Review of the physician's order sheet (POS) dated December 1, 2007 on January 9, 2008 at approximately 11:10 AM revealed that Resident #2 had a diagnosis of hypertension and was prescribed Lisinopril 5 mg. by mouth every day for blood pressure management. In an interview with the Licensed Practical Nurse (LPN) on January 9, 2008 at approximately 2:00 PM it was acknowledged that Resident #2 was administered Lisinopril 5 mg. by mouth every day. Further interview revealed that the Primary Care Physican (PCP) was made aware of the nephrologist's recommendation. Review of a nursing progress note dated December 18, 2007 on January 9, 2008 at approximately 2:15 PM revealed " [Resident #2] visted the nephrologist yesterday as scheduled due to abn. [abnormal] renal results per PCP order, MD notified of all recommendation[s] via voice mail and consult form with information faxed to him ...awaits return call." There was no documented evidence that the PCP addressed the nephrologist's recommendation that Resident #2's Lisinopril be increased from 5mg. every day to 10mg every day. 2. Observation at the day program during the	1401		2/12/08

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I 401	Continued From page 8 [Note: Review of the audiology consult dated January 4, 2008 on January 8, 2008 revealed that Resident #2 was uncooperative and was unable to be examined.] 4. The facility's nursing services failed to ensure that Resident #2's lithium levels were obtained in a timely manner as evidenced below: a. Review of the psychotropic medication review dated September 19, 2007 on January 8, 2008 at approximately 8:38 AM revealed a recommendation that Resident #2 have a repeat lithium level. Interview with the LPN on January 9, 2007 at approximately 10:00AM revealed that Resident #2 did go to the laboratory to have his lithium level drawn; however the hospital failed to draw the blood for the lithium level. Review of laboratory studies on January 9, 2008 at approximately 10:30AM revealed that there were not any lithium levels available for the month of September in the medical record. There was no documented evidence that the client's lithium level was obtained as in a timely manner. b. Review of the psychotropic medication review dated October 18, 2007 on January 8, 2008 at approximately 9:00 AM revealed a recommendation that Resident #2 have a repeat lithium level "stat." Interview and record review with the LPN on January 9, 2007 at approximately 1:00PM revealed that Resident #2 refused to have his lithium level drawn on October 18, 2007 and October 23, 2007. Further interview revealed that Resident #2 did have his lithium level obtained on October 26, 2006; however the hospital failed however the hospital failed to draw the blood for the lithium level. Review of a nursing progress note dated November 30, 2007 on January 9, 2008 at approximately 1:15 PM	I 401	1401 (4) SEE W338 (2)	2/12/08

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1401	<p>Continued From page 9</p> <p>revealed that the hospital had not drawn the lithium level on October 26, 2007. Review of a pharmacy medication review document dated November 29, 2007 revealed a recommendation to repeat lithium level. There was no documented evidence that the resident's lithium level was obtained immediately as requested.</p> <p>[Note: Review of laboratory studies on January 9, 2008 at approximately 1:20 PM revealed that the lithium level was not obtained until December 6, 2008.]</p> <p>5. The facility's nursing services failed to ensure that Resident #2's Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels were obtained in a timely manner as evidenced below:</p> <p>Review of the physician's progress note dated December 4, 2007 on January 9, 2008 at approximately 11:05 AM revealed that Resident #2 had a diagnosis of Vitamin D deficiency. Further review revealed that Resident #2 was prescribed Vitamin D 50,000 Iu 1.25 mg by mouth once a week times twelve weeks. Review of the Medication Administration Record (MAR) dated January, 2008 at approximately 4:27PM revealed that Resident #2 was prescribed Vitamin D 50,000 Iu 1.25 mg by mouth once a week times twelve weeks. Review of a laboratory study dated September 25, 2007 on January 9, 2008 at approximately 9:38 AM revealed a recommendation that Resident #2 have Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels repeated in twelve weeks. In an interview with the LPN on January 9, 2008 at approximately 12:45PM it was acknowledged that the Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels had not been repeated as recommended. Review of laboratory</p>	1401	<p>1401 (5) SEE W338 (3)</p>	2/12/08

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1401	Continued From page 10 studies on January 9, 2008 at approximately 10:30AM revealed that there were no available Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels documented since September 25, 2007. There was no documented evidence that the Vitamin D 25-OH T, Vitamin D 25-OH D3 and Vitamin D 25-OH D2 levels were obtained or scheduled in a timely manner. 6. The facility's nursing services failed to ensure that Resident #2's ANA level was obtained in a timely manner as evidenced below: Review of the physician's order sheet (POS) dated August 23, 2007 on January 9, 2008 at approximately 8:10 AM revealed that Resident #2 was ordered an ANA [microalbumin urine] level to be obtained. Further review revealed a recommendation for Resident #2 to be referred for a nephrology consult because of abnormal renal function tests. Review of the physician's progress note dated December 4, 2007 on January 9, 2008 at approximately 11:07 AM revealed a recommendation that Resident #2 have an ANA [microalbumin urine] level obtained prior to his nephrology follow-up on December 17, 2007. In an interview with the LPN on January 10, 2008 at approximately 11:45AM it was acknowledged that the ANA levels had been drawn; however the hospital failed to send the facility the results of the ANA levels. Review of laboratory studies on January 9, 2008 at approximately 10:30AM revealed that there was no documented ANA levels available in the medical record. There was no documented evidence that the resident's ANA levels were obtained in a timely manner.	1401	1401 (6) SEE W338 (4)	2/12/08
1420	3521.1 HABILITATION AND TRAINING	1420		

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1420	Continued From page 11 Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for one of two residents in the sample. (Resident #2) The finding includes: The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the Physical Therapist's (PT's) recommendation for Resident # 2 was addressed as evidenced by: Observation of Resident #2 at the day program on January 8, 2008 at approximately 10:30AM-12:00PM revealed that the client sat in chairs and ambulated in a forward bent over manner. Review of Resident #2's physician's order sheet (POS) dated December 1, 2007 on January 8, 2008 at approximately 2:11 PM revealed that the resident has a diagnosis of kyphoscoliosis. Review of the PT assessment dated March 21, 2007 on January 9, 2008 at approximately 11:36 AM revealed that Resident #2 was recommended to be considered for a scapular harness to promote more upright posture.	1420	1420 SEE W159 (3)	2/12/08
1423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident's Individual Habilitation Plan on an	1420		

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1423	<p>Continued From page 12</p> <p>ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP.</p> <p>This Statute is not met as evidenced by: Based on observations, interview, and record review, the GHMRP failed to ensure each resident's Individual Habilitation Plan had been monitored to make certain each resident participated and the plans were revised as needed.</p> <p>The findings include:</p> <p>1. Observations conducted at the day program on January 8, 2008 at starting at 9:15 AM revealed Resident #1's 1:1 staff had removed his adaptive helmet while sitting at the table with his peers. Further observations at 9:20 AM revealed Resident #1 was transported to the water fountain by his 1:1 staff. The 1:1 staff was observed to support Resident #1 with ambulating by keeping his overhand at his pelvis/trunk area, and by keeping his body close to the resident's without interfering with his movements. Interview with the day program Lead counselor at approximately 9:40 AM revealed he had not received training on Resident #1's new "Helmet and Ambulation Protocol." Further interview with the day program Case Manager at 9:51 AM revealed that they have not received a copy of the Resident #1's new protocols. Review of Resident #1's records revealed no evidence of the Helmet and Ambulation Protocols located in the records.</p> <p>Interview with the acting Qualified Mental Retardation Professional (QMRP)/Program</p>	1423	<p>1423 SEE W120</p>	2/12/08

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I 423	Continued From page 14 2. Observations conducted on January 8, 2008 at approximately 9:24 AM at the day program revealed Resident #1 identifying monetary coins at the table with his 1:1 staff. Interview with 1:1 staff on January 8, 2008 at approximately 9:51 AM revealed that Resident #1 has a program to identify coins. Review of the resident's Individual Program Plan (IPP) dated April 13, 2007 on January 8, 2008 at approximately 11:25 AM revealed a program objective which read "the resident will identify coins with 50% accuracy per session for three consecutive months. Review of the data collection sheets on January 9, 2008 at 3:14 PM revealed no documentation for the days of 10/10/07, 10/17, 10/24, 9/3/07, and 8/31/07. Interview with the QMRP on January 9, 2008 at approximately 3:30 PM acknowledged that the data was not being collected in accordance with the IPP. 3. Additional review of Resident #1's IPP on January 8, 2008 at approximately 11:27 AM revealed and objective which read "the resident will use a personal talker in response to query for personal information with 80% accuracy per session for 3 consecutive months. Interview with the 1:1 staff on January 7, 2008 at approximately 6:21 PM revealed that Client #1 has a communication device that he speaks into to record and repeat his personal information. Review of the data collection sheets on January 9, 2008 at 3:14 PM revealed no documentation for the days of 8/31/07, 9/3/07, 10/16/07, and 10/31/07. Interview with the QMRP on January 9, 2008 at approximately 3:30 PM acknowledged that the data was not being collected in accordance with the IPP.	I 423		2/12/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2008
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012		
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1473	Continued From page 15	1473		
1473	<p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of two residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Review of the nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11:00AM revealed that Based on staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Review of the nephrology consult dated December 17, 2007, on January 9, 2008 at approximately 11:00AM revealed that Resident #2 had a diagnosis of stable kidney disease Stage 2 probably from lithium toxicity from long standing use. Further review recommended "need to consider other alternatives to lithium." Review of the psychotropic medication review dated December 19, 2007 on January 9, 2008 at approximately 11:10 AM revealed a recommendation to decrease and discontinue lithium over three weeks. Review of the physician's order sheet (POS) dated December 19, 2007 on January 9, 2008 at approximately 11:30 AM revealed an order to administer Lithium</p>	1473	<p>1473 SEE W368</p>	2/12/08

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1473	Continued From page 16 300mg twice a day times seven days. Further review revealed an order to than administer Lithium 150mg twice a day, times seven days. Review of the Medication Administration Record (MAR) dated December 1, 2007 on January 9, 2008 at approximately 12:00 PM revealed that Resident #2 was administered Lithium 300mg twice a day by mouth from December 19, 2007 at 5:00 PM to December 26, 2007 at 5:00 PM. Further review revealed that Resident #2 was also administered Lithium 150mg by mouth on December 26, 2007 at 5:00PM. In an interview with the Licensed Practical Nurse (LPN) on January 10, 2008 at approximately 11:30AM it was acknowledged that the documentation on the MAR revealed that Resident #2 recieved Lithium 300mg and Lithium 150 mg by mouth on December 26, 2007 at 5:00 PM. Further interview revealed that the LPN did not think that Resident #2 actually was administered Lithium 450mg by mouth on December 26, 2007 at 5:00PM. There was no evidence that the physician was informed that the medication was not given in compliance with the physician's orders.	1473		2/12/08
1500	3523.1 RESIDENTS 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 observation, staff interview, and record review, the facility failed to establish a system that would ensure that residents were informed of their risks and benefits of their medication for one	1500		2/12/08

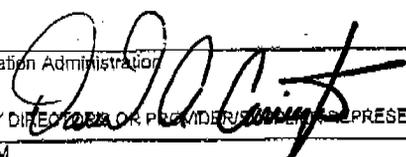
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2008
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1500	Continued From page 17 of the two residents in the sample. (Resident #2) The finding includes: Resident #2 was observed during the evening medication pass on January 7, 2008, at approximately 4:09 PM being administered Chlorpromazine 150 mg by mouth. Interview with the Licensed Practical Nurse (LPN) on January 7, 2008 at approximately 4:15 PM revealed that Resident #2 was prescribed the medication for behavior management. Review of the physician's order sheet (POS) dated December 1, 2007 on January 9, 2008 at approximately 11:15 AM revealed that Resident #2 has diagnoses of Intermittent Explosive Disorder (IED) and Schizophrenia; Chronic Undifferentiated Type and was prescribed Chlorpromazine 150 mg by mouth twice a day and Lithium 150mg every day for seven days. Lisinopril 5 mg. by mouth every day for behavior management. Interview with the Program Manager on January 8, 2007 at approximately 3:00 PM revealed that Resident #2's mother was very involved in his life but is not the resident's legal guardian. Review of Resident #2's, psychological assessment dated March 19, 2007 on January 9, 2008 at approximately 11:18 AM revealed that the resident does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Resident #2's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	1500	1500 SEE W124	2/12/08	

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R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for one of staff.</p> <p>The finding includes:</p> <p>Review of the review of personnel files on January 9, 2008 at 1:15 PM revealed the GHMRP failed provide evidence of a criminal background checks for the previous seven years in all jurisdiction where seven of twelve direct care staff had worked or resided. (Staff #4, #7, #8, #8, #10, #11, and #15).</p>	R 125	<p><u>R125</u></p> <p>ILS WILL ENSURE THAT CRIMINAL BACKGROUND CHECKS ARE OBTAIN FOR ALL EMPLOYEES PRIOR TO WORKING. ILS WILL CONTINUE TO IMPLEMENT IT'S EXISTENCE SYSTEM TO ENSURE THAT CRIMINAL BACKGROUND CHECKS ARE OBTAINED.</p>	2/12/08

Health Regulation Administration

LABORATORY DIRECTOR OR PROVIDER REPRESENTATIVE'S SIGNATURE

STATE FORM



TITLE

Executive Director

(X6) DATE

2/12/08

8899

R1X311

If continuation sheet 1 of 1