

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

PRINTED: 04/02/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/22/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOLUTIONS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from March 16, 2010 through March 22, 2010. A sample of two clients was selected from a population of four men with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process; however, due to concerns in the area of incident reporting and investigations, the process was extended on March 17, 2010, at 4:23 a.m., to review the facility's level of compliance in the Condition of Participation (CoP) for Client Protections.</p> <p>The findings of the survey were based on observations, interviews with staff and clients in the home and at one day program, as well as a review of client and administrative records, including incident reports.</p> <p>As a result of the extended survey in Client Protections, the SA determined that the facility: (1) failed to ensure that an effective system had been developed and implemented to make certain that significant incidents, including allegations of physical abuse, were reported and effectively addressed; and, (2) failed to adequately address Client #2's medical recommendations and/or provide services to ensure his health and safety. The facility's practices, therefore, posed likely harm to clients residing in the facility. On March 19, 2010, at approximately 1:30 p.m., the facility's Qualified Mental Retardation Professional (QMRP) and Incident Management Coordinator were notified of the immediate jeopardy.</p> <p>On March 19, 2010, at approximately 7:47 p.m. the facility's Executive Director and their Director of Nursing faxed to the SA a plan of correction to</p>	W 000	<p style="text-align: right;"><b>APR 26 2010</b></p> <p>Page 1 W 000 #1: The administration at ILS recognizes the importance of properly reporting and effectively addressing incidents. It has always been ILS's policy to promptly report all incidents to the appropriate agencies, including the DOH.</p> <p>Page 1 W 000 #1: The administration has reviewed ILS's policy on Incident Management/Reporting and Incident Management Protocol to ensure that said policy includes proper protocol for reporting incidents as well as effective incident follow up. All staff have been trained on Incident Management / Reporting on 3/19/2010, 3/20/2010, and 3/24/2010. ILS has also put into place a QA process to monitor the Incident Management Process and ensure thorough follow up.</p> <p>A new Incident Management Reporting and Follow Up Monitoring Tool will include: All fax confirmations verifying fax's sent to DOH reporting incidents will be turned into the Executive Director. The administration also took the action of replacing the Incident Management Coordinator. The administration at ILS also recognizes that all individuals have the right to be free from abuse and / or neglect. All staff received training on Individual Rights, Abuse and Neglect on 3/23/2010 and 3/26/2010.</p> <p>The administration at ILS recognizes the importance of ensuring every individual's health and safety through proper follow up of medical recommendations and services. ILS has and will continue to follow all recommendations regarding the health needs of it's individuals.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE **4/26/10**

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

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W 000	<p>Continued From page 1</p> <p>address the immediate jeopardy. The SA survey team held a telephone conference with the facility's Executive Director from approximately 8:10 p.m. to 8:15 p.m. The Executive Director agreed to supplement the proposed corrective plan by adding immediate training for staff assigned to work with Client #2 on the overnight shift that night (March 19, 2010). Compliance and implementation of the corrected actions must then be observed prior to the removal of the immediate jeopardy.</p> <p>The following was the plan submitted by the facility that outlined the proposed corrective measures:</p> <ol style="list-style-type: none"> <li>1. Staff will continue implementing Client #2's Ambulation Protocol, Fall Precautions and Helmet Protocol.</li> <li>2. Monthly monitoring by psychology/behavior specialist and physical therapist to ensure effectiveness of the plan and provide staff in-service trainings as needed.</li> <li>3. Nursing will monitor/assess Client #2 on a weekly basis or as needed and report to primary care physician and interdisciplinary team and changes in his condition.</li> <li>4. Staff will continue implementing Client #2's behavior support plan (BSP).</li> <li>5. Within 24 hours of March 19, 2010, 8:30 p.m.:             <ol style="list-style-type: none"> <li>a. Physical Therapist will re-evaluate and develop a program concerning Client #2 use of a soft cervical collar, gait belt, other supports and strategies to reduce his risks for falls;</li> </ol> </li> </ol>	W 000	<p>Page 2 W 000 #2: The administration at ILS recognizes the importance of Client #2's situation. Due to the complexity, monthly monitoring by the Behavioral Specialist/Psychology and Physical Therapist is needed to ensure effectiveness of the plan and provide staff training to all staff.</p> <p>Page 2 W 000 #3: The administration at ILS has implemented that Client #2 will be assessed/ monitored on a weekly basis and as needed. The LPN / RN will report to the PCP and Interdisciplinary Team any changes in his condition.</p> <p>Page 2 W 000 #4: The administration at ILS understands the importance of implementing all Individuals Behavioral Support Plans. All ILS staff was trained on the BSP on 3/20/2010.</p>	
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W 000 Continued From page 2

- b. Client #2's one-to-one staff supervision will be extended from the current 16 hours to 24 hours/day, 7 days/week;
- c. A discussion with the PCP and the neurosurgeon on their recommendation on the use of a soft collar prior to surgery. Upon approval of order for soft cervical collar, PT will develop a schedule for wearing the collar in increments to increase the likelihood that Client #2 will comply with the use of the collar;
- d. After evaluations and recommendations have been approved by the PCP, all staff will be trained extensively on these measures by the appropriate disciplines with 48 hours;
- e. Behavior Specialist will amend the current BSP to reflect strategies to address Client #2's behavioral issues/difficulties with redirection, use of his helmet, and tantrums which include throwing himself on the floor. Staff training will occur on the newly revised BSP within 48 hours;
- f. All staff will be trained on one-to-one support of Client #2 and the Health Management Care Plan within 24 hours;
- g. There will be training conducted by the Executive Director for managers on all Incident management and investigation policies and procedures. There will be further training conducted to all staff on incident reporting; and
- h. The Executive Director will review all incidents and fax confirmation sheets to ensure that government agencies are notified.

W 104 483.410(a)(1) GOVERNING BODY

W 000

- Page 2 W 000 #5 A:  
On March 19, 2010 the physical therapist re-evaluated the Ambulation Protocol, Fall Prevention, and Helmet Protocol. Working in conjunction with Nursing and the Behavioral Specialist a modified Protocol was written and implemented. A discussion of additional supports such as use of a gait belt and soft cervical collar occurred. It was determined that previous attempts to use a gait belt had failed as Client #2 would not allow it to be secured in place and often threw it on the floor. Amongst the concerns agreed by both the Nurse and Physical Therapist were 1) refusal to wear cervical collar, 2) increased risk of falls due to limitation of range of motion, 3) decreasing muscle strength due to dependence on collar. The Nurse addressed the recommendation and concerns with the PCP who did not feel it was warranted. On the following Monday, 3/23/20 the Nurse discussed with the Neurosurgeon the recommendation and concerns for using a soft cervical collar and he stated there would be no benefit.
- Page 3 W 000 #5B:  
Client #2 has had one-to-one supervision 24 hours a day 7 days a week since 3/19/2010.
- Page 3 W 000 #5C:  
A discussion with Client #2's PCP and Neurosurgeon concluded that a soft collar would not be beneficial. The Neurosurgeon felt it would only increase behaviors and risk of injury. Client #2 may not have to wear a collar post operatively.
- Page 3 W 000 #5D:  
Staff has been extensively trained on all new measures within 24 hours. 3/19/2010 and 3/20/2010
- Page 3 W 000 #5E:  
Staff has been trained on the newly revised BSP on 3/20/2010.
- Page 3 W 000 #5F:  
All staff were trained on one-to-one support of client #2 and HMCP on 3/19/2010 and 3/20/2010.
- Page 3 W 000 #5G:  
All managers were trained on Incident Management and Investigation Policies on 3/24/2010, 3/30/2010 and 4/6/2010. All staff were trained on 3/19/2010 and 3/20/2010.
- Page 3 W 000 #5H:  
The Executive Director is informed of any/all incidents And given a copy of fax confirmation to DOH.

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W 104 Continued From page 3

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's governing body provided general operating direction, except in the following areas:

The findings include:

1. Cross-refer to W192. The governing body failed to ensure that all staff were trained and competent to provide assistance in accordance with the health care needs (i.e. cervical spine condition, and commensurate safety precautions), of one of the two clients in the sample. (Client #2)
2. Cross-refer to W127.II. The governing body failed to ensure that the facility adequately addressed Client #2's medical recommendations and/or provided services to ensure his health and safety after receiving a December 15, 2009 warning that his spinal stenosis and myelopathy placed the client at increased risk of paralysis.
3. Cross-refer to W368. The governing body failed to ensure that the facility's nursing staff established a medication schedule to ensure that Client #3 received his Nexium 30 minutes before breakfast, in accordance with his physician's orders.
4. The governing body failed to ensure that the facility maintained in working order systems that

W 104

Page 4 W 104 #1 (Cross Refer W 192)

The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility.

Page 4 W 104 #2 (Cross Refer W 127 II)

ILS will continue to ensure all medical recommendations are implemented while ensuring individual safety. The medical recommendation was received on 12/15/09 of spinal stenosis, myelopathy and the risk of paralysis. ILS took multiple steps to ensure the safety of client #2 by training all staff on 3/20/2010 to include but not limited to BSP training, Helmet Protocol, Ambulation Protocol, One to One Protocol, HMCP, Fall Risk/Safety Protocol, and a second opinion MRI was completed due to the artifact from movement in the first MRI and could not be used to clearly determine client #2 condition. Multiple team meetings to discuss the recommendations to ensure client #2 safety has taken place.

Page 4 W 104 #3 (Cross Refer W 368):

The administration at ILS will ensure that all clients receive medications as prescribed by their physician. ILS provided training for all LPN's on medication administration on 4/10/2010 to ensure timely medication administration.

Page 4 W104 #4

ILS will ensure that all equipment is in good working order and work appropriately to ensure client safety. ABC burglary alarm was contacted to provide maintenance on 3/19/2010. We were informed that the alarm system was working, but had been inadvertently disabled. ILS will ensure we have a maintenance agreement and walk thru monthly.

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W 104	<p>Continued From page 4 were installed for client safety, as follows:</p> <p>Review of the Human Rights Committee minutes on March 19, 2010, at 4:08 p.m., revealed that door alarms were installed inside the facility for Client #2's health and safety. They were installed on all doors leading to the outside.</p> <p>On March 22, 2010, at approximately 2:30 p.m., interview with the QMRP revealed that the alarm had not been working for two weeks. She then made a phone call and indicated that the facility was in the process of making arrangements to fix the alarm.</p> <p>During the March 22, 2010 Exit Conference, at 4:57 p.m., the Executive Director indicated that the alarm system had been installed on all exterior doors of the facility because both Clients #1 and #2 had longstanding targeted maladaptive behaviors of attempting to leave their home without staff escort. Note: The Executive Director acknowledged that prior to March 19, 2010, neither of the two clients received one-to-one staff supervision during the overnight hours.</p>	W 104		
W 122	<p><b>483.420 CLIENT PROTECTIONS</b></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 observation, interview and record review, the facility failed to ensure an effective system to protect Client #2's health and safety [W127]; and, the facility failed to ensure the immediate notification of the State Agency of</p>	W 122	<p>Page 5 W 122</p> <p>The administration at ILS acknowledges that staff failed to ensure immediate notification to the State Agency of allegations of abuse, although ILS has standard policies and protocols, additional measures taken to address this issue include: Review and modification of incident management policy, incident management training to include procedure for reporting to DOH in a timely matter, policy modification to ensure executive director signs off on all incidents, and installation of a new Incident Management Coordinator.</p>	

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W 122 Continued From page 5  
allegations of abuse [Refer to W153].  
  
The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being.

W 122

W 127 483.420(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.

W 127

This STANDARD is not met as evidenced by:  
I. Based on interview and record review, the facility failed to ensure that an effective system had been developed and implemented to make certain that significant incidents, including allegations of physical abuse, were reported and effectively addressed

The findings include:  
  
On March 17, 2010, beginning at 10:53 a.m., review of incident reports in the facility revealed ongoing head injuries sustained by Client #2, as follows:

- a. On January 19, 2010, a residential staff person was observed by two witnesses hitting Client #2 in the head and shoulder outside his day program. The staff was assigned to provide the client one-to-one support to address his maladaptive behaviors and unsteady gait. Police arrested the staff for assault on the same day.
- b. Client #2 was taken to an emergency room

Page 6 W 127 A  
ILS will continue to ensure all clients are free from abuse and neglect and any allegations are effectively reported to all government agencies and addressed in a timely matter. All staff was trained on 3/23/2010 and All ILS staff will continue to be trained on Client Rights, Abuse and Neglect. ILS will also continue to follow the appropriate process as it relates to notification of government agencies as well as notifying the Metropolitan police department.

Page 6 W127 B  
ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait. All ILS staff was trained on 3/20/2010.

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<p>W 127</p>	<p>Continued From page 6 (ER) for evaluation and treatment of head injuries after falls/loss of balance on February 13, 2009 and March 18, 2009.</p> <p>c. Client #2 sustained six other injuries to his head due to falls/loss of balance: on January 6, 2009, January 25, 2009, April 24, 2009, June 25, 2009, November 3, 2009 and February 20, 2010. Other incident reports documented that Client #2 injured his head during behavioral episodes on January 27, 2009, February 2, 2009, December 3, 2009, December 30, 2009 and January 4, 2010.</p> <p>d. Staff took Client #2 to an ER after he hit his head on a floor during a behavioral episode September 29, 2009. The hospital discharge report indicated the primary diagnosis was "closed head injury" with secondary diagnosis "laceration, left eyelid."</p> <p>The facility failed to report the aforementioned head injuries, ER visits and alleged (substantiated) physical abuse to the State Agency, in accordance with federal and state regulations.</p> <p>II. Based on observation, interview and record review, the facility failed to adequately address Client #2's medical recommendations and/or provide services to ensure his health and safety.</p> <p>The findings include:</p> <p>During the March 16, 2010 Entrance Conference, at 5:40 p.m., the Facility Coordinator and Qualified Mental Retardation Professional reported that Client #2's medical guardian and interdisciplinary team (IDT) were exploring</p>	<p>W 127</p>	<p>Page 7 W127 C ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait for client #2. ILS will also provide modification of the BSP to adequately support individual safety. During this period, multiple trainings in fall protocol and helmet protocol were performed with staff on 3/20/2010.</p> <p>Page 7 W127 D ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait. ILS will also provide modification of the BSP to adequately support individual safety. During this period, multiple trainings in fall protocol and helmet protocol were performed with staff on 3/20/2010. The administration at ILS will ensure appropriate timeliness of reporting all incidents to government agencies.</p> <p>Page 7 W127 II The previous Neurosurgeon failed to communicate the severity of Client #2's condition and would not return the Legal Guardian's calls. During Client #2's initial evaluation with the second opinion Neurosurgeon, Client #2's risk factors and safety were discussed. It was learned at that time that the current MRI was questionable due to artifact from movement and could not be used to clearly determine Client #2's Condition. A repeat MRI under deep sedation would have to be performed. Physical Therapy evaluated client #2 multiple times and provided training to staff on ambulation and helmet safety.</p> <p>Page 7 W127 II ILS will continue to ensure all medical recommendations are implemented while ensuring individual safety by providing ongoing quality assurance medical review. The RN provided training for all LPN's on 4/10/2010.</p>	
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W 127	<p>Continued From page 7</p> <p>whether to proceed with surgery to his cervical spine, as recommended by two neurosurgeons. Subsequent observations, interviews and record review revealed an immediate risk to Client #2's health and safety, as follows:</p> <p>1. On March 17, 2010, beginning at 9:02 a.m., Client #2 was observed repeatedly refusing to cooperate with the morning medication nurse. At 9:04 a.m., the client removed his helmet and laid on the floor. His behaviors escalated and he became combative with staff. He repeatedly got up off the floor but would then refuse to let the nurse test his blood pressure. He balled his fist and tried to hit his one-to-one staff several times before dropping back to the floor. He repeatedly threw his safety helmet across the room and at 9:09 a.m., he threw a cup of water to the floor.</p> <p>During the course of his tantrums, staff told him they would take him to McDonald's if he cooperated (not an approved strategy in his Behavior Support Plan, dated April 2009). The nurse stopped trying to take his blood pressure, saying he would hold the client's hypertensive medication. He stirred the client's other morning medications into pudding and tried administering them. The client refused and laid back on the floor. The nurse called it "snack" but when the client stood up and/or sat on a chair, he again refused his medications and went back down onto the floor. At 9:15 a.m., the client ate the pudding with medications, and the nurse said "thank you very much" and then shook his hand. Later review of the Behavior Support Plan revealed that offering the client praise so soon after his tantrum behaviors was contraindicated in the plan. The nurse and staff were ineffective in addressing Client #2's behavioral needs.</p>	W 127	<p>Page 8 W127 #1 ILS realizes that offering "McDonalds" as a strategy for cooperative behavior is not appropriate, but walking is listed as an appropriate strategy to deescalate the behavior and staff will often take walks as client #2 enjoys. ILS has trained all staff on the revised BSP, demonstrated tantrum-like behaviors, and the helmet protocol on 3/20/2010.</p> <p>Page 8 W127 second paragraph The "thank you" was provided to positively reinforce client # 2 for taking the medication, not praising him for the tantrum-like behavior he exhibited prior to taking the medication. ILS staff was trained on the BSP on 3/20/2010.</p>	
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W 127	<p>Continued From page 8</p> <p>2. As noted in paragraph 1 above, documentation in Client #2's record indicated that he had experienced repeated, ongoing injuries to his head, due to falls or behavioral episodes.</p> <p>3. Client #2's annual Medical Evaluation, dated March 20, 2008, included: "repeated accidental injury and abnormal gait led to the investigation for the cause of the problem. MRI of the spine showed cervical spine spondylosis and lumbar disc protrusion. MRI of the brain pending. Will continue with measures of injury prevention such as wearing helmet, gait and muscle strengthening exercise and behavioral therapy." Gait training, behavior therapy and one-to-one supervision during waking hours were among the recommendations. The client's Medical Evaluation dated March 13, 2009, included: "Repeated fall and head injury. Repeated ER visit. History of nasal bone fracture. Lumbar disc disease, cervical stenosis ... gait instability." Behavior management, neurosurgeon evaluation regarding spinal stenosis and one-to-one supervision during waking hours were among the recommendations. Client #2's Individual Support Plan (ISP), dated April 13, 2009, prescribed: one-to-one staff support for 16 hours daily, included a Behavior Support Plan (BSP), an Ambulation Protocol and a Helmet Protocol. His support plan remained essentially unchanged since then, despite frequent documented falls and/or injuries and ER visits.</p> <p>4. On June 12, 2009, Client #2's IDT met to review the risks and benefits of surgery to address cervical stenosis and myelopathy, as recommended by a neurosurgeon on May 11, 2009. The IDT expressed "unanimous concern</p>	W 127	<p>Page 9 W127 #2 ILS has trained all staff on the revised BSP, demonstrated tantrum-like behaviors, and the helmet protocol on 3/20/2010.</p> <p>Page 9 W127 #3 The administration at ILS acknowledges the complexity of Client #2 and the need for continuous reassessment. ILS will continue to ensure safe and adequate support. ILS has added 24 hour one to one support for client #2 on 3/19/2010 as well as addressed behavioral supports with modification of the psychotropic medication on 3/30/2010.</p> <p>Page 9 W127 #4 The administration at ILS recognizes the importance of ensuring every individual's health and safety through proper follow up of medical recommendations and services. ILS has and will continue to follow all recommendations regarding health needs of it's individuals.</p> <p>Page 9 W127 #4 The administration at ILS maintains that medical recommendations concerning client #2 have been addressed as warranted. Client # 2 had an initial diagnostic work up involving several MRI's due to an unsteady gait and frequent falls. Client #2's PCP referred client #2 to a Neurologist. Client #2 was seen by the Neurologist whom recommended a repeat MRI. Client #2 was also evaluated by the Physical Therapist to re-evaluate fall precautions and helmet safety concerns. Client #2 was seen by the Neurosurgeon and the consult documentation returned stated "Findings: Cervical stenosis with myelopathy and recommending surgery. Client #2 was again evaluated by Physical Therapist. An IDT meeting was held to discuss the teams concerns regarding client #2's ability to recover from the recommended surgery. The IDT was unanimous in their concerns</p>
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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>
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**W 127** Continued From page 9

whether such surgery would" benefit the client and recommended that the medical guardian communicate with the neurosurgeon. On September 29, 2009, a DC Superior Court judge ordered the ICF/MR to facilitate communication between the medical guardian and the neurosurgeon. The judge also ordered the facility to seek the opinion of DC Health Resources Partnership (DCHRP) regarding Client #2's cervical spine condition and the proposed surgery.

In an email dated December 15, 2009, the DCHRP Project Director informed the facility that the neurosurgeon recommending surgery indicated that given his physical anatomy, "the patient's movement is compromising the cord periodically. This is significant given the fact that this client has a history of recurrent falls. This patient has an increased risk of complications resulting from falling and sustaining injury to the cord. Minor movement in just the right direction or position could lead to quadriplegia in this client." There was no evidence, however, that the facility made any changes to his support plan after receiving the warning of increased potential for risk of paralysis.

5. On March 16, 2010 and March 17, 2010, at 6:02 p.m. and 9:22 a.m., respectively, Client #2 was observed not wearing his protective helmet while ambulating in the facility and/or going out to the driveway. The Helmet Protocol, dated September 24, 2009, stated that he should wear it while awake, unless eating or showering. Although staff indicated that falling to the floor and removing his helmet were frequent behaviors, review of Client #2's BSP on March 17, 2010, beginning at 5:21 p.m., revealed no

**W 127**

regarding whether the surgery would be beneficial related to client #2's inability to participate in rehabilitation and wear a cervical collar if needed. The first neurosurgeon stated " the patient has C3-C5 pathology with signal changes behind C4 vertebral body involving the cord periodically. This is significant given the fact that this client has a history of recurrent falls. The patient has an increased risk of complications resulting from falling and sustaining injury to the cord. Minor movement in just the right position could lead to quadriplegia." The IDT and PCP were made aware of this new information that was not provided with the original consult. Client #2 had a second opinion with another Neurosurgeon. Documentation of client #2's history of the current problem as well as films of previous MRI's were provided. A discussion via phone with the Neurosurgeon and RN during the consult occurred to address the IDT's concerns regarding surgery and the newly provided information from the previous Neurosurgeon. It was communicated by the second opinion Neurosurgeon that the MRI was of poor quality and another MRI would need to be done. The MRI took place and a follow up appointment with the second opinion Neurosurgeon was attended by the Legal Guardian and Behavioral Specialist and QMRP. Recommendation was made for surgery. A post operative plan was prepared and discussed with the IDT.

Page 10 W127 #5  
ILS will ensure that all training, steps and measures will be taken to ensure the safety of client #2. Training for helmet protocol, ambulation, fall risk/safety protocol and BSP was conducted on 3/19/2010 and 3/20/2010. Client # 2 has the right to refuse and ambulate without his protective helmet at any time. ILS will continue to redirect client #2 as outlined in his BSP and ensure his safety at all measures.

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W 127	<p>Continued From page 10</p> <p>evidence that the consulting behavior specialist and/or the supervisory psychologist had proposed intervention strategies for those behaviors to ensure his health and safety.</p> <p>6. On March 18, 2010, between 3:45 p.m. - 4:30 p.m., separate interviews with two of Client #2's one-to-one staff revealed that neither staff was aware of his spinal condition. On March 19, 2010, at 8:53 a.m., interview with the one-to-one staff observed with him at the morning medication pass on March 17, 2010 revealed that he too was previously unaware of the spinal stenosis and myelopathy and/or that the client was at increased risk of paralysis.</p> <p>7. On March 18, 2010, beginning at 12:30 p.m., review of staff in-service training records revealed no evidence that the two staff assigned to the overnight shift (12:00 a.m. - 8:00 a.m.) had received training regarding Client #2's spinal condition, BSP, Ambulation Protocol and Helmet Protocol.</p> <p>8. On March 18, 2010, at 12:45 p.m., review of the personnel file for the staff person that was arrested on January 19, 2010 revealed that he had begun working in the facility in August 2009. Subsequent review of staff in-service training records revealed no evidence that he had received training on Client #2's BSP, Ambulation Protocol and Helmet Protocol prior to being assigned to provide the client with one-to-one support.</p> <p>Immediate jeopardy was called on March 19, 2010, at 1:30 p.m. after determining that there was no evidence that the facility sought to establish interim, protective measures to ensure</p>	W 127	<p>Page 11 W127 #6 The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility.</p> <p>Page 11 W127 #7 The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility. ILS has also trained all staff on client #2 BSP, Ambulation protocol and helmet protocol.</p> <p>Page 11 W127 #8 The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility. ILS has also trained all staff on client #2 BSP, Ambulation protocol and helmet protocol.</p>	
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W 127	<p>Continued From page 11</p> <p>Client #2's health and safety after receiving a December 15, 2009 warning that his spinal stenosis and myelopathy placed the client at increased risk of paralysis.</p> <p>III. On March 19, 2010, the survey team remained onsite until the facility submitted a Corrective Action Plan, at 7:47 p.m., that included the following:</p> <ol style="list-style-type: none"> <li>1. Staff will continue implementing Client #2's Ambulation Protocol, Fall Precautions and Helmet Protocol;</li> <li>2. Monthly monitoring by psychology/behavior specialist and physical therapist to ensure effectiveness of the plan and provide staff in-service trainings as needed;</li> <li>3. Nursing will monitor/assess Client #2 on a weekly basis or as needed and report to primary care physician and interdisciplinary team and changes in his condition;</li> <li>4. Staff will continue implementing Client #2's behavior support plan (BSP); and</li> <li>5. Within 24 hours of March 19, 2010, 8:30 p.m.:             <ol style="list-style-type: none"> <li>a. Physical Therapist will re-evaluate and develop a program concerning Client #2 use of a soft cervical collar, gait belt, other supports and strategies to reduce his risks for falls;</li> <li>b. Client #2's one-to-one staff supervision will be extended from the current 16 hours to 24 hours/day, 7 days/week;</li> <li>c. A discussion with the PCP and the</li> </ol> </li> </ol>	W 127	<p>Page 12 W127 paragraph 2 ILS will continue to ensure all medical recommendations are implemented while ensuring individual safety. The medical recommendation was received on 12/15/09 of spinal stenosis, myelopathy and the risk of paralysis. ILS took multiple steps to ensure the safety of client #2 to include but not limited to BSP training, Helmet Protocol, Ambulation Protocol, One to One Protocol, HMCP, Fall Risk/Safety Protocol, and a second opinion MRI was completed due to the artifact from movement in the first MRI and could not be used to clearly determine client #2 condition. Multiple team meetings to discuss the recommendations to ensure client #2 safety has taken place.</p> <p>Page 12 W127 #1 ILS will ensure that all training, steps and measures will be taken to ensure the safety of client #2. Training for helmet protocol, ambulation, fall risk/safety protocol and BSP was conducted on 3/19/2010 and 3/20/2010. Client # 2 has the right to refuse and ambulate without his protective helmet at any time. ILS will continue to redirect client #2 as outlined in his BSP and ensure his safety at all measures.</p> <p>Page 12 W127 #2 ILS will ensure monthly monitoring by psychologist/behavior specialist and physical therapist to ensure effectiveness of the plan and provide continuous training to ILS staff. ILS was trained on 3/20/2010.</p> <p>Page 12 W127 #3 ILS will continue to ensure that client #2 BSP, Fall protocol, Ambulation protocol and helmet protocol are being implemented.</p> <p>Page 12 W127 #4 ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait for client #2. ILS will also provide modification of the BSP to adequately support individual safety. During this period, multiple trainings in fall protocol and helmet protocol were performed with staff on 3/20/2010.</p> <p>Page 12 W127 A Physical therapist evaluated client #2 for a soft cervical collar and gait. Recommendation was client #2 would not benefit from wearing a soft Cervical collar and would only further increase his unsteady gait.</p>	
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W 127 Continued From page 12  
neurosurgeon on their recommendation on the use of a soft collar prior to surgery. Upon approval of order for soft cervical collar, PT will develop a schedule for wearing the collar in increments to increase the likelihood that Client #2 will comply with the use of the collar;

d. After evaluations and recommendations have been approved by the PCP, all staff will be trained extensively on these measures by the appropriate disciplines with 48 hours;

e. Behavior Specialist will amend the current BSP to reflect strategies to address Client #2's behavioral issues/difficulties with redirection, use of his helmet, and tantrums which include throwing himself on the floor. Staff training will occur on the newly revised BSP within 48 hours;

f. All staff will be trained on one-to-one support of Client #2 and the Health Management Care Plan within 24 hours;

g. There will be training conducted by the Executive Director for managers on all incident management and investigation policies and procedures. There will be further training conducted to all staff on incident reporting; and

h. The Executive Director will review all incidents and fax confirmation sheets to ensure that government agencies are notified.

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other

W 127  
Page 12 W127B  
ILS has ensured client #2 safety by modifying his one to one supervision from 16 hours in 24 hours a day/7 days a week. Training was conducted on 3/19/2010.

Page 12 W127 C  
Neurosurgeon did not agree with client #2 wearing a soft cervical collar and physical therapist assessed client #2 and did not agree as well with the use of a cervical collar.

Page 13 W127 E  
BSP was amended and all staff was trained by the Psychologist/Behavior Specialist on 3/20/2010.

Page 13 W127 F  
The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility.

Page 13 W127 G  
ILS will ensure that all managers and staff are trained on incident management, investigation policies and procedures. ILS's executive director conducted a training on 3/24/2010. (see attached training sheet)

Page 13 W127 H  
The administration at ILS will ensure that the executive director review all incidents and fax confirmations sheets to ensure that all government agencies are notified in a timely matter of all incidents.

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W 153	<p>Continued From page 13</p> <p>officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of incident reports and investigations, the facility failed to ensure that all allegations of abuse were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA), for one of the four clients residing in the facility. (Client #2)</p> <p>The finding includes:</p> <p>On March 17, 2010, beginning at 10:53 a.m., the facility's incident reports and incident management system were reviewed. According to one incident report, a residential staff person was observed by two witnesses physically assaulting Client #2 (hitting him in the head and shoulder) on January 19, 2010, outside his day program. Police were called and the accused staff was placed under arrest. HRLA was not notified of this incident.</p>	W 153	<p>Page 14 W153 paragraph 1</p> <p>ILS will continue to ensure all clients are free from abuse and neglect and any allegations are effectively reported to all government agencies and addressed in a timely matter. All ILS staff will continue to be trained on Client Rights, Abuse and Neglect. ILS will also continue to follow the appropriate process as it relates to notification of government agencies as well as notifying the Metropolitan police department. All ILS staff was trained on 3/20/2010.</p>	
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for one of the two clients in the sample. (Client #1)</p>	W 159		

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W 159 Continued From page 14

The findings include:

1. On March 22, 2010, at approximately 1:00 p.m., review of Client #1's psychotropic medication review revealed that absconding attempts was identified and reviewed as a target behavior. Further review revealed that the client had attempted to abscond on February 19, 2010, and four other times in 2009. Previously, on March 18, 2010, review of the client's Behavior Support Plan (BSP) dated April 2009, had not identified absconding as one of his targeted behaviors. Instead, it listed physical aggression, self injurlous behavior, property destruction and stealing food as his target behaviors.

On March 22, 2010, at approximately 1:15 p.m., interview with the QMRP and the incident management coordinator/quality assurance specialist confirmed that Client #1 had attempted to abscond. They further acknowledged that attempts to abscond should have been addressed in the BSP.

There was no evidence that the QMRP ensured that Client #1's BSP addressed all known target behaviors, including leaving the facility without a staff escort.

2. Cross-refer W249. The QMRP failed to ensure that facility staff consistently implemented Client #1's communication program (i.e. using manual signs) as recommended in his IPP.

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.

W 159

page 15 W159 #1

ILS will ensure that client #1 BSP includes his attempts on absconding from the facility. On 3/20/2010, the psychologist modified the BSP to reflect client #1 absconding attempts.

Page 15 W159 #2

ILS will ensure that client #1's IPP is implemented by the QMRP. The QMRP has completed training on active treatment.

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W 192	<p>Continued From page 15</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff received training to address clients' health needs, for one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>On March 18, 2010, between 3:45 p.m. - 4:30 p.m., separate interviews with staff who were observed providing one-to-one support for Client #2 at various times during the survey revealed that neither staff was aware of his spinal condition (spinal stenosis and myelopathy). On March 19, 2010, at 8:53 a.m., interview with another (third) staff, the one-to-one staff who was observed with Client #2 at the morning medication pass on March 17, 2010 revealed that he too was previously unaware of the spinal stenosis and myelopathy and/or that the client was at increased risk of paralysis.</li> <li>On March 18, 2010, beginning at 12:30 p.m., review of staff in-service training records revealed no evidence that the two staff assigned to the overnight shift (12:00 a.m. - 8:00 a.m.) had received training regarding Client #2's spinal condition, Behavior Support Plan, Ambulation Protocol and Helmet Protocol.</li> <li>On March 18, 2010, at 12:45 p.m., review of the personnel file for a staff person that was arrested on January 19, 2010 for assaulting Client #2 revealed that he had begun working in the facility in August 2009. Subsequent review of staff in-service training records revealed no evidence that he had received training on Client</li> </ol>	W 192	<p>Page 16 W192 #1 The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility. ILS has also trained all staff on client #2 BSP, Ambulation protocol and helmet protocol.</p> <p>Page 16 W192 #2 &amp; 3 ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait for client #2. ILS will also provide modification of the BSP to adequately support individual safety. During this period, multiple trainings in fall protocol and helmet protocol were performed with staff on 3/20/2010.</p>	
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W 192 Continued From page 16  
#2's Behavior Support Plan, Ambulation Protocol and Helmet Protocol prior to being assigned to provide the client with one-to-one support

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:  
Based on observation, staff interview, and record verification, the facility failed to implement a client's Individual Support Plan (ISP), for one of the two clients in the sample. (Client #1)

The finding includes:

Observation on March 16, 2010, at 5:20 p.m., revealed Client #1's 1:1 direct support staff telling him to bring a basket of clothes upstairs. At 6:01 p.m., the 1:1 direct support staff was observed telling him to go into the bathroom to wash his hands. At 6:05 p.m., the client was observed to follow the 1:1 staff to the dining room table for dinner. At 6:18 p.m., the client was observed drinking hot chocolate. Interview with the staff at the same time revealed that they sometimes gave him hot chocolate instead of coffee.

Review of Client #2's IPP dated March 1, 2010, on March 22, 2010, at 8:30 a.m., revealed an objective for Client #1 that stated, given a model,

W 192

W 249

Page 17 W249 (D) (1)  
ILS will ensure that all staff continues to be trained on each individuals active treatment as outlined in their IPP book. Training was provided on 3/23/2010.

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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOLUTIONS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>
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W 249	<p>Continued From page 17</p> <p>the client will manually sign the following words: eat, drink, clothes, coffee, wash, sleep, home, walk, throw and television. On March 22, 2010, at 11:30 a.m., review of the client's speech and language evaluation, dated April 10, 2010, revealed a goal to manually sign ten pictures of daily living activities upon request with 80% accuracy per session for three consecutive months. Further review revealed that the client increased his functional communication skills as a result of his participation in functional communication programming. However, at no time during the survey were any of the 1:1 staff observed using signs while communicating with Client #1.</p> <p>Interview with the qualified mental retardation professional on March 22, 2010 at approximately 2:00 p.m., revealed that she had observed a female staff using manual signs with Client #1. She acknowledged that she had not observed other staff using manual signs. Throughout the survey, Client #1 had received one-to-one support from male staff.</p> <p>There was no evidence that facility staff consistently implemented Client #1's communication program as recommended in the IPP.</p>	W 249		
W 252	<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:</p>	W 252		

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W 252	<p>Continued From page 18</p> <p>Based on observation and record review, facility staff failed to document all behavior data in accordance with the behavior support plan (BSP), for one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>On March 17, 2010, between 9:02 a.m. - 9:15 a.m., Client #2 was observed refusing several attempts by the medication nurse to take his blood pressure. The client's behaviors escalated from refusals, to dropping to the floor, throwing his safety helmet across the room, throwing a cup of water onto the floor, and he made several attempts to hit his one-to-one staff in the face.</p> <p>On March 18, 2010, at 9:12 a.m., review of Client #2's behavior support plan (BSP), dated April 2009, revealed that staff were instructed to document each incident of targeted maladaptive behaviors on the designated behavior data collection sheets.</p> <p>On March 22, 2010, at approximately 2:15 p.m., review of Client #2's behavior data sheets revealed that staff had not documented the incident of tantruming and physical aggression that occurred during the medication pass on March 17, 2010.</p>	W 252	<p>Page 19 W252 (E) (1) ILS will ensure that all staff continues to document all behavior data in accordance with the behavior support plan (BSP). ILS staff was trained on the BSP on 3/20/2010.</p>	
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W 325	<p>482.460(a)(3)(iii) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p>	W 325		
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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>
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W 325	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <p>On March 22, 2010, at approximately 10:50 a.m., review of Client #2's annual Medical Evaluations dated March 20, 2008 and March 13, 2009, as well as his monthly physician's orders during that 2-year period, revealed ongoing orders for him to receive laboratory studies every six months to assess his Thyroid functioning and Lithium Carbonate serum levels. Subsequent review of his medical records revealed the last documented laboratory studies for the aforementioned tests were dated July 7, 2009.</p> <p>In an interview with the Registered Nurse (RN) on March 22, 2010, at 11:25 a.m., it was acknowledged that more recent lab reports were not in Client #2's chart. At 11:46 a.m., the RN indicated that she had just learned that the client went for labs that Saturday (March 20, 2010). The psychiatrist reportedly ordered the lab tests upon review of the client's chart on March 19, 2010, as part of his monthly psychotropic medication review. At 11:54 a.m., the RN presented the reports/findings of the lab tests that were performed March 20, 2010. She then acknowledged that the tests had been due two months earlier, in January 2010.</p>	W 325	<p>Page 20 W325 paragraph 1 ILS will ensure that all clients receive medications as prescribed by their physician. ILS will ensure that all LPN's continues to be trained on medication administration and lab sheet schedule. ILS provided training to all LPN's on 4/10/2010.</p>	
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W 368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with</p>	W 368		
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W 368	<p>Continued From page 20 the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with physician's orders, for one of the four clients residing in the facility. (Client #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The morning medication administration pass was observed on March 17, 2010, beginning at 7:58 a.m. At 8:37 a.m., the medication nurse administered Client #3's medications, including Nexium 40 mg capsule. On March 19, 2010, at 4:50 p.m., review of Client #3's March 2010 physician's orders revealed that he was prescribed "Nexium 40 mg capsule, twice daily. Give 30 minutes before breakfast and dinner." The client, however, had already finished his breakfast before he received the Nexium on March 17, 2010.</li> <li>2. During the Entrance Conference on March 16, 2010, at 5:27 p.m., the facility coordinator and qualified mental retardation professional reported that the clients' typical, daily morning routine had them eating breakfast at approximately 6:30 a.m. or 7:00 a.m. Clients then received their medications after breakfast and left for day programs shortly thereafter.</li> </ol> <p>The facility's nursing staff failed to establish a nursing schedule to ensure that Client #3 received his Nexium 30 minutes before breakfast, in accordance with his physician's orders.</p>	W 368	<p>I.L.S will ensure that all LPN's continues to be trained on medication administration to include med pass procedures and lab sheet schedule. I.L.S provided training to all LPN's on 4/10/2010.</p>	
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W 381	483.460(I)(1) DRUG STORAGE AND	W 381		
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOULTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012		
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W 381	Continued From page 21 RECORDKEEPING  The facility must store drugs under proper conditions of security.  This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that drugs were consistently stored under proper conditions of security, for four of the four clients residing in the facility. (Clients #1 through #4)  The findings include:  The morning medication pass was observed on March 17, 2010 beginning at 7:58 a.m. On two occasions, the medication nurse left the medication closet unlocked in the home office while he went elsewhere in the facility, thereby leaving medications unsecured, as follows:  1. Upon arrival, the nurse washed his hands, retrieved pudding and new medication cups from the medication closet. At 8:00 a.m., the nurse left the closet door open while he went to use the restroom. The medications in the closet were left unsecured.  2. At 8:02 a.m., the nurse returned to the office. The nurse, however, left the room again just moments later, following behind Client #2 and his one-to-one staff person. For approximately two minutes, the nurse was gone, the closet door remained open and the medications were left unsecured.	W 381	Page 22 W381 ILS will ensure that all medications are properly stored and locked at the facility.  ILS will ensure that all LPN's continues to be trained on medication administration to include med pass procedures and lab sheet schedule. ILS provided training to all LPN's on 4/10/2010.		
W 436	483.470(g)(2) SPACE AND EQUIPMENT  The facility must furnish, maintain in good repair, and teach clients to use and to make informed	W 436			

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**W 436** Continued From page 22

choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure adaptive equipment were being furnished, monitored and maintained as recommended, for one of two clients in the sample. (Client #2)

The findings include:

Observation on March 16, 2010, beginning at 6:10 p.m., revealed Client #2's dinner was served in a hi-low plate. During the meal, the plate was positioned so that the highest side was opposite the client, and the low side was closest to his body. Client #2 was observed scooping his food towards himself, with food spilling over the low side of his plate onto the table as well as his shirt.

Interview with the 1:1 direct support staff on March 16, 2010, at 6:33 p.m., indicated he was not sure where the high or low side of the plate should be positioned. Further interview confirmed that the 1:1 direct support staff had observed the food spillage throughout the meal.

On March 19, 2010, at approximately 11:00 a.m., review of Client #2's individual support plan (ISP), dated April 13, 2009, confirmed that the client was prescribed a plate guard to reduce food spillage.

The facility failed to ensure Client #2's hi-low plate

**W 436**

ILS will ensure that all staff continues to be trained on all adaptive equipment for all clients. ILS will also continue to ensure that all clients are taught how to use their adaptive equipment by staff. Training was provided by QMRP on adaptive equipment and infectious control on 2/17/2010.

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W 436 Continued From page 23  
was positioned correctly to reduce food spillage.  
W 455 483.470(I)(1) INFECTION CONTROL

W 436  
W 455

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

This STANDARD is not met as evidenced by:  
Based on observation and record review, the facility failed to ensure proper infection control procedures, for one of the four clients residing in the facility. (Client #2)

The finding includes:

Observation on March 16, 2010, beginning at 6:10 p.m., revealed Client #2 received his dinner in a hi-low plate. During the meal, the scdop plate was not in proper position and food was observed spilling onto the table and the client's shirt while he ate. At 6:13 p.m., a spoonful of chicken fell between the table and his shirt. The client proceeded to pick up the chicken and he put it in his mouth. At 6:16 p.m., more food fell onto the table and the client proceeded to eat it as well. At 6:23 p.m., the 1:1 direct support staff assisting him at the meal pointed to food that had fallen onto the client's shirt. The client looked at the food that the staff was pointing to, and then picked it up and ate it. At 6:33 p.m., the client was again observed eating food that had spilled onto the table.

Review of staff in-service training records on March 19, 2010, at 9:45 a.m., revealed that a nurse had conducted training on infection control on June 17, 2009. However, there was no evidence that proper infection control procedures

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W 455	Continued From page 24 were implemented consistently by all staff.	W 455		
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/22/2010
NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOULTIONS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012	
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1 000	INITIAL COMMENTS  A licensure survey was conducted from March 16, 2010 through March 22, 2010. A sample of two residents was selected from a population of four men with varying degrees of cognitive and intellectual disabilities.  The findings of the survey were based on observations, interviews with residents and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.	1 000	
1 226	3510.5(c) 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 observation and record review, the GHMRP failed to ensure that all staff and residents were effectively trained on infection control procedures, for one of the four residents residing in the facility. (Resident #2)  The finding includes:  Observation on March 16, 2010, beginning at 6:10 p.m., revealed Resident #2 received his dinner in a hi-low plate. During the meal, the scoop plate was not in proper position and food was observed spilling onto the table and the resident's shirt while he ate. At 6:13 p.m., a spoonful of chicken fell between the table and his shirt. The resident proceeded to pick up the chicken and he put it in his mouth. At 6:16 p.m., more food fell onto the table and the resident	1 226	ILS will ensure that all staff continues to be trained on all adaptive equipment for all clients. ILS will also continue to ensure that all clients are taught how to use their adaptive equipment by staff. Training was provided by QMRP on adaptive equipment and infectious control on 2/17/2010.

Health Regulation Administration

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

STATE FORM

TITLE

(X6) DATE

EXECUTIVE DIRECTOR 4/26/10

8896

SECT11

If continuation sheet 1 of 13

Health Regulation Administration

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I 226	Continued From page 1  proceeded to eat it as well. At 6:23 p.m., the 1:1 direct support staff assisting him at the meal pointed to food that had fallen onto the resident's shirt. The resident looked at the food that the staff was pointing to, and then picked it up and ate it. At 6:33 p.m., the resident was again observed eating food that had spilled onto the table.  Review of staff in-service training records on March 19, 2010, at 9:45 a.m., revealed that a nurse had conducted staff training on infection control on June 17, 2009. However, there was no evidence that proper infection control procedures were implemented consistently by all staff. In addition, there was no evidence that residents received training whenever appropriate.	I 226		
I 230	3510.5(g) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (g) Habilitation planning and implementation;  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff received training to on residents' habilitation plan and specialized needs, for one of the two residents in the sample. (Resident #2)  The findings include:  1. On March 18, 2010, beginning at 12:30 p.m., review of staff in-service training records revealed no evidence that the two staff assigned to the overnight shift (12:00 a.m. - 8:00 a.m.) had received training regarding Resident #2's spinal condition (spinal stenosis and myelopathy),	I 230	The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility. ILS has also trained all staff on client #2 BSP. Ambulation protocol and helmet protocol.	

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I 230 Continued From page 2  
Behavior Support Plan, Ambulation Protocol and Helmet Protocol.

2. On March 18, 2010, at 12:45 p.m., review of the personnel file for a staff person that was arrested on January 19, 2010 for assaulting Resident #2 revealed that he had begun working in the facility in August 2009. Subsequent review of staff in-service training records revealed no evidence that he had received training on Resident #2's Behavior Support Plan, Ambulation Protocol and Helmet Protocol prior to being assigned to provide the resident with one-to-one support.

On March 18, 2010, at 1:23 p.m., the Incident Management Coordinator (and immediate-past Qualified Mental Retardation Professional) acknowledged that there was no written documentation that the above-referenced staff had received training on Resident #2's habilitation needs. No additional information was made available before the survey ended on March 22, 2010.

I 230

The administration at ILS recognizes the importance of being knowledgeable and competent in providing assistance with the medical needs of our clients. All staff were trained on each clients HMCP and specific medical needs on 3/19/2010 and 3/20/2010. ILS will continue to ensure that the HMCP and specific medical needs of each individual is part of each staff person's orientation and initial training upon entering the facility. ILS has also trained all staff on client #2 BSP, Ambulation protocol and helmet protocol.

The administration at ILS recognizes the importance of properly reporting and effectively addressing incidents. It has always been ILS's policy to promptly report all incidents to the appropriate agencies, including the DOH.

I 379 3519.10 EMERGENCIES

In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.

I 379

The administration has reviewed ILS's policy on Incident Management/Reporting and Incident Management Protocol to ensure that said policy includes proper protocol for reporting incidents as well as effective incident follow up. All staff have been trained on Incident Management / Reporting on 3/19/2010, 3/20/2010, and 3/24/2010. ILS has also put into place a QA process to monitor the Incident Management Process and ensure thorough follow up.

A new Incident Management Reporting and Follow Up Monitoring Tool will include: All fax confirmations verifying fax's sent to DOH reporting incidents will be turned into the Executive Director. The administration also took the action of replacing the Incident Management Coordinator. The administration at ILS also recognizes that all individuals have the right to be free from abuse and / or neglect. All staff received training on Individual Rights, Abuse and Neglect on 3/23/2010 and 5/26/2010.

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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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
I 379	<p>Continued From page 3</p> <p>This Statute is not met as evidenced by: Based on interviews and review of incident reports and investigations, the facility failed to ensure that all allegations of abuse and other incidents that placed resident health and safety at risk were reported immediately to the Department of Health, Health Regulation and Licensing Administration (HRLA), for two of the four residents of the facility. (Residents #2 and #3)</p> <p>The findings include:</p> <p>On March 17, 2010, beginning at 10:53 a.m., the facility's incident reports and incident management system were reviewed.</p> <p>1. According to one incident report, a residential staff person was observed by two witnesses physically assaulting Resident #2 (hitting him in the head and shoulder) on January 19, 2010, outside his day program. Police were called and the accused staff was placed under arrest. HRLA was not notified of this incident.</p> <p>2. Further review of incident reports revealed that since January 1, 2009, Resident #2 received evaluation and treatment in hospital emergency rooms. HRLA had not been notified of the following incidents:</p> <p>a. On February 13, 2009, the resident lost his balance while flushing a toilet. He hit his head on the toilet seat, sustained a gash on the forehead and was taken to an emergency room (ER) for further assessment and treatment.</p> <p>b. On March 18, 2009, at 4:30 p.m., Resident #2 fell again, while ambulating in the kitchen. He</p>	I 379	<p>The administration at ILS acknowledges that staff failed to ensure immediate notification to the State Agency of allegations of abuse, although ILS has standard policies and protocols, additional measures taken to address this issue include: Review and modification of incident management policy, incident management training to include procedure for reporting to DOH in a timely matter, policy modification to ensure executive director signs off on all incidents, and installation of a new Incident Management Coordinator.</p> <p>ILS will continue to ensure all clients are free from abuse and neglect and any allegations are effectively reported to all government agencies and addressed in a timely matter. All ILS staff will continue to be trained on Client Rights, Abuse and Neglect. ILS will also continue to follow the appropriate process as it relates to notification of government agencies as well as notifying the Metropolitan police department. All ILS staff was trained on 3/20/2010.</p> <p>All managers were trained on Incident Management and Investigation Policies on 3/24/2010, 3/30/2010 and 4/6/2010. All staff were trained on 3/19/2010 and 3/20/2010.</p>

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I 379	Continued From page 4  sustained a 1 1/2 inch cut on his left forehead, after which he was taken to the ER as per the physician's order, and received sutures.  c. An incident report, dated September 29, 2009, documented a behavioral episode in which Resident #2 hit his forehead on the floor of a courthouse. He was taken to an ER for treatment of a laceration to his left eye lid.  3. Another incident report, dated February 14, 2010, documented that Resident #3 was taken to an ER due to chest pains, nausea and vomiting. HRLA was not notified of this incident.	I 379	The administration at ILS recognizes the importance of ensuring every individual's health and safety through proper follow up of medical recommendations and services. ILS has and will continue to follow all recommendations regarding health needs of it's individuals.  ILS will ensure that all managers and staff are trained on incident management, investigation policies and procedures. ILS's executive director conducted a training on 3/24/2010. (see attached training sheet)
I 401	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 staff interview and record verification, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for one of the two residents in the sample. (Resident #2)  The findings include:  On March 22, 2010, at approximately 10:50 a.m., review of Resident #2's annual Medical Evaluations dated March 20, 2008 and March 13, 2009, as well as his monthly physician's orders for the 2-year period, revealed ongoing orders for him to receive laboratory studies every six	I 401	The administration at ILS has implemented that Client #2 will be assessed/ monitored on a weekly basis and as needed. The LPN / RN will report to the PCP and Interdisciplinary Team any changes in his condition.  ILS will continue to ensure all medical recommendations are implemented while ensuring individual safety by providing ongoing quality assurance medical review. The RN provided training for all LPN's on 4/10/2010.

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I 401	Continued From page 5  months to assess his Thyroid functioning and Lithium Carbonate serum levels. Subsequent review of his medical records revealed the last documented laboratory studies for the aforementioned tests were dated July 7, 2009.  In an interview with the Registered Nurse (RN) on March 22, 2010, at 11:25 a.m., it was acknowledged that more recent lab reports were not in Resident #2's chart. At 11:46 a.m., the RN indicated that she had just learned that the resident went for labs that Saturday (March 20, 2010). The psychiatrist reportedly ordered the lab tests upon review of the resident's chart on March 19, 2010, as part of his monthly psychotropic medication review. At 11:54 a.m., the RN presented the reports/findings of the lab tests that were performed March 20, 2010. She then acknowledged that the tests had been due two months earlier, in January 2010.	I 401		
I 422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interview, and record verification, the GHMRP failed to implement a resident's Individual Support Plan (ISP), for one of the two residents in the sample. (Resident #1)  The finding includes:  Observation on March 16, 2010, at 5:20 p.m., revealed Resident #1's 1:1 direct support staff telling him to bring a basket of clothes upstairs. At 6:01 p.m., the 1:1 direct support staff was observed telling him to go into the bathroom to	I 422	The administration at ILS recognizes the importance of ensuring every individual's health and safety through proper follow up of medical recommendations and services. ILS has and will continue to follow all recommendations regarding the health needs of it's individuals.  All staff were trained on one-to one support of client #2 and HMCP on 3/19/2010 and 3/20/2010.	

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I 422	Continued From page 6  wash his hands. At 6:05 p.m., the resident was observed to follow the 1:1 staff to the dining room table for dinner. At 6:18 p.m., the resident was observed drinking hot chocolate. Interview with the staff at the same time revealed that they sometimes gave him hot chocolate instead of coffee.  Review of Resident #2's IPP dated March 1, 2010, on March 22, 2010, at 8:30 a.m., revealed an objective for Resident #1 that stated, given a model, the resident will manually sign the following words: eat, drink, clothes, coffee, wash, sleep, home, walk, throw and television. On March 22, 2010, at 11:30 a.m., review of the resident's speech and language evaluation, dated April 10, 2010, revealed a goal to manually sign ten pictures of daily living activities upon request with 80% accuracy per session for three consecutive months. Further review revealed that the resident increased his functional communication skills as a result of his participation in functional communication programming. However, at no time during the survey were any of the 1:1 staff observed using signs while communicating with Resident #1.  Interview with the qualified mental retardation professional on March 22, 2010 at approximately 2:00 p.m., revealed that she had observed a female staff using manual signs with Resident #1. She acknowledged that she had not observed other staff using manual signs. Throughout the survey, Resident #1 had received one-to-one support from male staff.  There was no evidence that facility staff consistently implemented Resident #1's communication program as recommended in the IPP.	I 422	ILS will ensure that client #1's IPP is implemented by the QMRP. The QMRP has completed training on active treatment.		

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I 500 3523.1 RESIDENT'S RIGHTS

I 500

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:  
A. Based on observation, interview and record review, the GHMRP failed to ensure the health and safety of one of the two residents in the sample. (Resident #2)

The findings include:

During the March 16, 2010 Entrance Conference, at 5:40 p.m., the Facility Coordinator and Qualified Mental Retardation Professional reported that Resident #2's medical guardian and interdisciplinary team (IDT) were exploring whether to proceed with surgery to his cervical spine, as recommended by two neurosurgeons. Subsequent observations, interviews and record review revealed an immediate risk to Resident #2's health and safety, as follows:

1. On March 17, 2010, beginning at 9:02 a.m., Resident #2 was observed repeatedly refusing to cooperate with the morning medication nurse. At 9:04 a.m., the resident removed his helmet and laid on the floor. His behaviors escalated and he became combative with staff. He repeatedly got up off the floor but would then refuse to let the nurse test his blood pressure. He balled his fist and tried to hit his one-to-one staff several times before dropping back to the floor. He repeatedly threw his safety helmet across the room and at 9:09 a.m., he threw a cup of water to the floor.

ILS will continue to ensure all medical recommendations are implemented while ensuring individual safety. The medical recommendation was received on 12/15/09 of spinal stenosis, myelopathy and the risk of paralysis. ILS took multiple steps to ensure the safety of client #2 by training all staff on 3/20/2010 to include but not limited to BSP training, Helmet Protocol, Ambulation Protocol, One to One Protocol, HMCP, Fall Risk/Safety Protocol, and a second opinion MRI was completed due to the artifact from movement in the first MRI and could not be used to clearly determine client #2 condition. Multiple team meetings to discuss the recommendations to ensure client #2 safety has taken place.

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1500	<p>Continued From page 8</p> <p>During the course of his tantrums, staff told him they would take him to McDonald's if he cooperated (not an approved strategy in his Behavior Support Plan, dated April 2009). The nurse stopped trying to take his blood pressure, saying he would hold the resident's hypertensive medication. He stirred the resident's other morning medications into pudding and tried administering them. The resident refused and laid back on the floor. The nurse called it "snack" but when the resident stood up and/or sat on a chair, he again refused his medications and went back down onto the floor. At 9:15 a.m., the resident ate the pudding with medications, and the nurse said "thank you very much" and then shook his hand. Later review of the Behavior Support Plan revealed that offering the resident praise so soon after his tantrum behaviors was contraindicated in the plan. The nurse and staff were ineffective in addressing Resident #2's behavioral needs.</p> <p>2. As noted in paragraph 1 above, documentation in Resident #2's record indicated that he had experienced repeated, ongoing injuries to his head, due to falls or behavioral episodes.</p> <p>3. Resident #2's annual Medical Evaluation, dated March 20, 2008, included: "repeated accidental injury and abnormal gait led to the investigation for the cause of the problem. MRI of the spine showed cervical spine spondylosis and lumbar disc protrusion. MRI of the brain pending. Will continue with measures of injury prevention such as wearing helmet, gait and muscle strengthening exercise and behavioral therapy." Gait training, behavior therapy and one-to-one supervision during waking hours were among the recommendations. The resident's Medical Evaluation dated March 13, 2009, included:</p>	1500	<p>ILS realizes that offering "McDonalds" as a strategy for cooperative behavior is not appropriate, but walking is listed as an appropriate strategy to deescalate the behavior and staff will often take walks as client #2 enjoys. ILS has trained all staff on the revised BSP, demonstrated tantrum-like behaviors, and the helmet protocol on 3/20/2010.</p> <p>The "thank you" was provided to positively reinforce client # 2 for taking the medication, not praising him for the tantrum-like behavior he exhibited prior to taking the medication. ILS staff was trained on the BSP on 3/20/2010.</p> <p>ILS has trained all staff on the revised BSP, demonstrated tantrum-like behaviors, and the helmet protocol on 3/20/2010.</p> <p>ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait. All ILS staff was trained on 3/20/2010.</p>	

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I 500	<p>Continued From page 9</p> <p>"Repeated fall and head injury. Repeated ER visit. History of nasal bone fracture. Lumbar disc disease, cervical stenosis ... gait instability." Behavior management, neurosurgeon evaluation regarding spinal stenosis and one-to-one supervision during waking hours were among the recommendations. Resident #2's Individual Support Plan (ISP), dated April 13, 2009, prescribed: one-to-one staff support for 16 hours daily, included a Behavior Support Plan (BSP), an Ambulation Protocol and a Helmet Protocol. His support plan remained essentially unchanged since then, despite frequent documented falls and/or injuries and ER visits.</p> <p>4. On June 12, 2009, Resident #2's IDT met to review the risks and benefits of surgery to address cervical stenosis and myelopathy, as recommended by a neurosurgeon on May 11, 2009. The IDT expressed "unanimous concern whether such surgery would" benefit the resident and recommended that the medical guardian communicate with the neurosurgeon. On September 29, 2009, a DC Superior Court judge ordered the ICF/MR to facilitate communication between the medical guardian and the neurosurgeon. The judge also ordered the facility to seek the opinion of DC Health Resources Partnership (DCHRP) regarding Resident #2's cervical spine condition and the proposed surgery.</p> <p>In an email dated December 15, 2009, the DCHRP Project Director informed the facility that the neurosurgeon recommending surgery indicated that given his physical anatomy, "the patient's movement is compromising the cord periodically. This is significant given the fact that this resident has a history of recurrent falls. This patient has an increased risk of complications</p>	I 500	<p>ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait for client #2. ILS will also provide modification of the BSP to adequately support individual safety. During this period, multiple trainings in fall protocol and helmet protocol were performed with staff on 3/20/2010.</p> <p>The administration at ILS maintains that medical recommendations concerning client #2 have been addressed as warranted. Client #2 had an initial diagnostic work up involving several MRI's due to an unsteady gait and frequent falls. Client #2's PCP referred client #2 to a Neurologist. Client #2 was seen by the Neurologist whom recommended a repeat MRI. Client #2 was also evaluated by the Physical Therapist to re-evaluate fall precautions and helmet safety concerns. Client #2 was seen by the Neurosurgeon and the consult documentation returned stated "Findings: Cervical stenosis with myelopathy and recommending surgery. Client #2 was again evaluated by Physical Therapist. An IDT meeting was held to discuss the teams concerns regarding client #2's ability to recover from the recommended surgery. The IDT was unanimous in their concerns regarding whether the surgery would be beneficial related to client #2's inability to participate in rehabilitation and wear a cervical collar if needed. The first neurosurgeon stated " the patient has C3-C5 pathology with signal changes behind C4 vertebral body involving the cord periodically. This is significant given the fact that this client has a history of recurrent falls. The patient has an increased risk of complications resulting from falling and sustaining injury to the cord. Minor movement in just the right position could lead to quadriplegia." The IDT and PCP were made aware of this new information that was not provided with the original consult. Client #2 had a second opinion with another Neurosurgeon. Documentation of client #2's history of the current problem as well as films of previous MRI's were provided. A discussion via phone with the Neurosurgeon and RN during the consult occurred to address the IDT's concerns regarding surgery and the newly provided information from the previous Neurosurgeon. It was communicated by the second opinion Neurosurgeon that the MRI was of poor quality and another MRI would need to be done. The MRI took place and a follow up appointment with the second opinion Neurosurgeon was attended by the Legal Guardian and Behavioral Specialist and QMRP. Recommendation was made for surgery. A post operative plan was prepared and discussed with the IDT.</p>	

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I 500	<p>Continued From page 10</p> <p>resulting from falling and sustaining injury to the cord. Minor movement in just the right direction or position could lead to quadriplegia in this resident." There was no evidence, however, that the facility made any changes to his support plan after receiving the warning of increased potential for risk of paralysis.</p> <p>5. On March 16, 2010 and March 17, 2010, at 6:02 p.m. and 9:22 a.m., respectively, Resident #2 was observed not wearing his protective helmet while ambulating in the facility and/or going out to the driveway. The Helmet Protocol, dated September 24, 2009, stated that he should wear it while awake, unless eating or showering. Although staff indicated that falling to the floor and removing his helmet were frequent behaviors, review of Resident #2's BSP on March 17, 2010, beginning at 5:21 p.m., revealed no evidence that the consulting behavior specialist and/or the supervisory psychologist had proposed intervention strategies for those behaviors to ensure his health and safety.</p> <p>6. On March 18, 2010, between 3:45 p.m. - 4:30 p.m., separate interviews with two of Resident #2's one-to-one staff revealed that neither staff was aware of his spinal condition. On March 19, 2010, at 8:53 a.m., interview with the one-to-one staff observed with him at the morning medication pass on March 17, 2010 revealed that he too was previously unaware of the spinal stenosis and myelopathy and/or that the resident was at increased risk of paralysis.</p> <p>7. On March 18, 2010, beginning at 12:30 p.m., review of staff in-service training records revealed no evidence that the two staff assigned to the overnight shift (12:00 a.m. - 8:00 a.m.) had received training regarding Resident #2's spinal</p>	I 500	<p>The administration at ILS understands the importance of implementing all Individuals Behavioral Support Plans. All ILS staff was trained on the BSP on 3/20/2010.</p> <p>ILS will ensure that all staff continues to be trained on fall precautions, one to one training and gait for client #2. ILS will also provide modification of the BSP to adequately support individual safety. During this period, multiple trainings in fall protocol and helmet protocol were performed with staff on 3/20/2010.</p> <p>ILS will ensure monthly monitoring by psychologist/behavior specialist and physical therapist to ensure effectiveness of the plan and provide continuous training to ILS staff. ILS was trained on 3/20/2010.</p> <p>BSP was amended and all staff was trained by the Psychologist/Behavior Specialist on 3/20/2010.</p>	

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I 500	<p>Continued From page 11</p> <p>condition, BSP, Ambulation Protocol and Helmet Protocol.</p> <p>8. On March 18, 2010, at 12:45 p.m., review of the personnel file for the staff person that was arrested on January 19, 2010 revealed that he had begun working in the facility in August 2009. Subsequent review of staff-in-service training records revealed no evidence that he had received training on Resident #2's BSP, Ambulation Protocol and Helmet Protocol prior to being assigned to provide the resident with one-to-one support.</p> <p>Immediate jeopardy was called on March 19, 2010, at 1:30 p.m. after determining that there was no evidence that the facility sought to establish interim, protective measures to ensure Resident #2's health and safety after receiving a December 15, 2009 warning that his spinal stenosis and myelopathy placed the resident at increased risk of paralysis.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure the residents' right to receive medications in accordance with physician's orders, for one of the four residents of the facility. (Resident #3)</p> <p>The findings include:</p> <p>1. The morning medication administration pass was observed on March 17, 2010, beginning at 7:58 a.m. At 8:37 a.m., the medication nurse administered Resident #3's medications, including Nexium 40 mg capsule. On March 19, 2010, at 4:50 p.m., review of Resident #3's March 2010 physician's orders revealed that he was prescribed "Nexium 40 mg capsule, twice daily. Give 30 minutes before breakfast and dinner."</p>	I 500	<p>ILS will continue to ensure all clients are free from abuse and neglect and any allegations are effectively reported to all government agencies and addressed in a timely manner. All staff was trained on 3/23/2010 and All ILS staff will continue to be trained on Client Rights, Abuse and Neglect. ILS will also continue to follow the appropriate process as it relates to notificatinn of government agencies as well as notifying the Metropolitan police department.</p> <p>ILS will continue to ensure all medical recommendations are implemented while ensuring individual safety. The medical recommendation was received on 12/15/09 of spinal stenosis, atyelopathy and the risk of paralysis. ILS took multiple steps to ensure the safety of client #2 to include but not limited to BSP training, Helmet Protocol, Ambulation Protocol, One to One Protocol, HMCP, Fall Risk/Safety Protocol, and a second opinion MRI was completed due to the artifact from movement in the first MRI and could not be used to clearly determine client #2 condition. Multiple team meetings to discuss the recommendations to ensure client #2 safety has taken place.</p> <p>ILS will ensure that all LPN's continues to be trained on medication administration to include med pass procedures and lab sheet schedule. ILS provided training to all LPN's on 4/10/2010.</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/22/2010
NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOULTIONS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	<p>Continued From page 12</p> <p>The resident, however, had already finished his breakfast before he received the Nexium on March 17, 2010.</p> <p>2. During the Entrance Conference on March 16, 2010, at 5:27 p.m., the facility coordinator and qualified mental retardation professional reported that the residents' typical, daily morning routine had the m eating breakfast at approximately 6:30 a. m. or 7:00 a. m. Residents then received their medications after breakfast and left for day programs shortly thereafter.</p> <p>The facility's nursing staff failed to establish a nursing schedule to ensure that Resident #3 received his Nexium 30 minutes before breakfast, in accordance with his physician's orders.</p> <p>C. Cross-refer to I422. Based on observation, interview and record review, the facility failed to ensure Client #1's right to receive habilitation and training (specifically, his communication goal using manual signs), in accordance with his ISP.</p>	I 500	<p>I.L.S will ensure that all clients receive medications as prescribed by their physican. I.L.S will ensure that all LPN's continues to be trained on medication administration and lab sheet schedule. I.L.S provided training to all LPN's on 4/10/2010.</p> <p>I.L.S will ensure that all staff continues to be trained on each individuals active treatment as outlined in their IPP book. Training was provided on 3/23/2010.</p>	