

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

PRINTED: 05/11/2010  
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  R <b>04/29/2010</b>
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{W 000}

INITIAL COMMENTS

{W 000}

A revisit was conducted on April 29, 2010, to verify the facility's compliance with condition-level deficiencies cited during the March 22, 2010, recertification survey. One client remained in the sample from the previous survey, due to the nature of the citations. One new client was added from a residential population of four men with various disabilities. The findings of the survey were based on observations in the home, interviews with clients and staff (direct support, nursing and administrative), as well as a review of clinical, administrative, and habilitative records, including a review of unusual incident reports.

*Received  
DOH 5/24/10*

W 322

The revisit resulted in a determination that the facility had regained compliance with the Condition of Participation in Client Protections. 483.460(a)(3) PHYSICIAN SERVICES

W 322

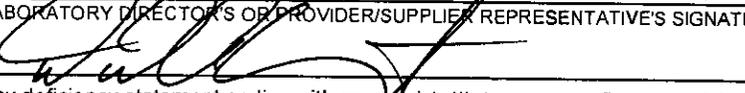
The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's medical team failed to ensure timely assessment and treatment of allergy symptoms, for one of the two clients in the sample. (Client #3)

The findings include:

1. Facility staff failed to alert nursing staff of observed symptoms, as follows:

On April 29, 2010, at approximately 7:32 a.m., Client #3 coughed and sneezed while seated in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>EXECUTIVE DIRECTOR</b>	(X6) DATE <b>5/20/10</b>
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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 322	<p>Continued From page 1</p> <p>the living room. A direct support staff person brought a paper napkin and he wiped his nose. When he sneezed again, the staff person told him that she would inform the medication nurse upon his arrival later that morning. At 7:36 a.m., Client #3 wiped his nose again and thr�w away the paper napkin. Upon seeing him toss the napkin in the trash, the staff person instructed the client to use hand sanitizer. Congestion could be heard in his sinuses while he breathed. The client was observed coughing and sneezing several more times before he left the facility with staff and his peers. At 12:05 p.m., interview with the facility's LPN revealed that she was unaware of a client showing signs or symptoms of illness. A short while later, the medication nurse informed the RN by telephone that staff had not reported any coughing, sneezing or nasal congestion. Subsequent review of Nurse's Notes and daily progress notes in Client #3's record did not reflect any reference to coughing, sneezing or runny nose that morning.</p> <p>2. The facility's medical team failed to ensure accurate records of Client #3's history and management of respiratory allergies, as follows:</p> <p>On April 29, 2010, at 3:35 p.m., review of Client #3's Individual Support Plan from a year earlier, dated April 13, 2009, revealed the following: "Claritin 10 mg by mouth PRN for respiratory allergies." This information, however, was not reflected in the client's Health Management Care Plan, dated December 5, 2009, or in the RN Annual and Quarterly Nursing Assessments performed in the past 12 months. In addition, the client's Medical Evaluation dated March 13, 2010, indicated "Claritin 10 mg qd PRN;" however, the</p>	W 322	<p>RN completed training with facility staff on April 30, 2010 regarding the importance of observing clients for signs and symptoms of medical complications as well as reporting the information to the nursing staff. In addition, the RN reviewed the Health Maintenance Care Plan of all clients with the direct care staff.</p> <p>Direct care staff will continue to monitor all clients for signs and symptoms of medical complications and communicate any observance to the nursing staff.</p> <p>Claritin 10mg was ordered for 7 days for allergy symptoms and discontinued on January 15, 2008. The medical evaluation completed by the physician on March 13, 2010 listed Claritin as an active medication in error. This medication was not implemented on the physician orders or nurses notes, as it was not part of active treatment for the client. To address client's current allergy symptoms, a new order for Claritin 10mg for two weeks has been written.</p>	
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W 322	Continued From page 2 primary care physician did not include Claritin on his physician's orders.	W 322	Program Director completed training with nursing staff on May 20, 2010 regarding reviewing documentation on clients, including medical evaluation, consult reports and staff notes to ensure accuracy of health complications and current medications.  Nursing staff and Program Director will continue to review documentation and participate in randomly auditing medical records.		