

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

PRINTED: 05/17/2011
FORM APPROV
OMB NO. 0938-02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2011
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)

W 000 INITIAL COMMENTS

A recertification survey was conducted from April 27, 2011, through April 29, 2011. A random sampling of three clients was selected from a residential population of five males with varying degrees of intellectual disabilities. Due to condition level deficiencies cited during the previous survey, the full survey process was utilized to review the facility's compliance.

The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.

W 104 483.410(a)(1) GOVERNING BODY

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

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility, as evidenced by the deficiencies cited throughout this report, for five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5).

The findings include:

1. The governing body failed to ensure staff was trained to effectively implement active treatment programs. (See W189 and W193)
2. The governing body failed to ensure that the primary licensed practical nurse (LPN) was

W 000

Received 6/13/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
800 North Capitol St., N.E.
Washington, D.C. 20002

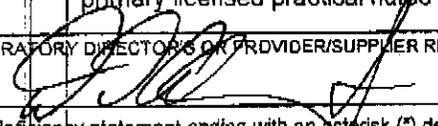
W 104: W104.1

See W189, See W 193

W104.2

6/15/11

Innovative Life Solutions will ensure that the primary Licensed Practical Nurse (LPN) is licensed to practice in the District of Columbia. The LPN was placed on Administrative Leave until she has received a current District of Columbia license. On May 10, 2011, the RN Supervisor provided training to LPN coordinator which included medication administration, securing medications, hand hygiene and disposal of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE RESE DIERITO	(X6) DATE 6/10/11
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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 104	Continued From page 1 licensed to practice in the District of Columbia, as evidenced below: On April 27, 2011, at 8:40 a.m., Nurse #1 indicated that she was preparing to administer the morning medication to the clients. Further discussion with the nurse revealed that she was the facility's primary LPN and that she had been employed by the agency for approximately two months. Further discussion with the administrator on April 29, 2011, at approximately 4:30 p.m., confirmed that the primary LPN had been employed by the agency for approximately two months. Observation of the medication administration on April 27, 2011, from 8:45 a.m., to 9:40 a.m., revealed several medication errors. During interview with the LPN after the medication administration, the LPN acknowledged the errors. On April 29, 2011, at approximately 3:30 p.m., record review revealed the LPN was licensed to practice in Virginia and had "Multi-State Privilege." The LPN was informed that follow-up would be conducted to determine if the multi-state license was valid in the District of Columbia, and that she would be notified accordingly. (The surveyors' post-exit consultation with the Director of the DC Board of Nursing on May 2, 2011, revealed that the aforementioned nursing license was not valid in the District of Columbia.)	W 104	medications. Medication administration training for all of the nurses working with Innovative Life Solutions as been scheduled for on June 15, 2011. LPN also received a disciplinary action for failing to ensure that medications are given as per Physician Order Sheet as well as failing securing an appropriate District of Columbia license.		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services	W 120			

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W 120	Continued From page 2 meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of three clients in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #3's day program implemented his individual program plan, as evidenced below: Observation on April 28, 2011, at 11:30 a.m., revealed Client #3 ate chill and salad, and also drank tropical fruit punch and water. After the meal, the client's one-on-one staff removed the tray from the table and handed the tray to the day program staff. Record review on April 28, 2011, at 12:10 p.m., revealed Client #3 had a day program goal to improve his activity of daily living skills. The objective stated, "When given verbal prompt, the client will clean-up his eating area after lunch 80% of trials per month." Interview with the one-on-one staff on the same day at 12:25 p.m., acknowledged that the client did not clean up his eating area as required.	W 120	W120 Innovative Life Solutions will ensure that the day program implements the individual's program plans by providing ongoing in-service trainings to the staff. On May 7, 2011 the staff was in-serviced on program goal implementation. On June 7, 2011 the Facility Coordinator went to the Day Program and provided an in-service to Client # 3's staff regarding his goal implementation.	6/7/11	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159			

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W 159	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified intellectual disability professional (QIDP), for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: 1. The QIDP failed to effectively coordinate and monitor Client #1's behavior management, as evidenced below: On April 27, 2011 at 12:45 p.m., the review of unusual incidents revealed on August 6, 2010, at 3:56 p.m., while sitting at the dining room table, Client #1 attempted to take another individual's [Client #2's] food. In response, the individual [Client #2] bit Client #1 on his head, causing a laceration. The investigation report, dated August 12, 2010, revealed the client required sutures at the emergency room for a "bite-human, assault." The investigation report further noted that Client #1 had a behavior support plan which addressed "taking others food/snacks/drinks" that do not belong to him and "grabbing" and that he should be provided one on one supervision to prevent this behavior. Further review of the incident report revealed at the time of the incident Client #2's targeted behaviors included biting. Client #2's behavior support plan dated April 2010 "Staff should regularly monitor the environment for increases in stimulation and be prepared to minimize this."	W 159	W159.1 Innovative Life Solutions will ensure that each client's active treatment program is integrated, coordinated and monitored by the QIDP. The QIDP will notify the Behavior Specialist when the individuals are involved in a behavior related incident within 24 hours of occurrence. On May 7, 2011, the residential staff received an in-service training on BSP implementation to address the implementation of behavior management techniques. The QIDP received an in-service training on May 19, 2011 to address communicating with consultants, client safety and monitoring active treatment.	5/19/11	

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W 159	Continued From page 4 Interview with the QIDP on April 27, 2011, 12:50 p.m. revealed that the BSPs of Client #1 and Client #2 did not prescribe one on one supervision, however, that both required close monitoring. Further interview with the QIDP revealed that she monitored the client's targeted behaviors monthly. On April 28, 2011 at 3:37 p.m., review of Client #1's QIDP summary for August 2010 revealed "0" documented incidents of his targeted behaviors of "taking food/snacks/drinks" that do not belong to him and "grabbing". The client's BSP dated July 23, 2010, confirmed that his targeted behaviors included "taking food/snacks/drinks" that do not belong to him and "grabbing" should be monitored. Continued review of the August 2010 QIDP summary revealed no evidence that the August 6, 2010 incident was included, and noted that "[Client] had no reportable/serious reportable incidents for (the)month. Staff and team will continue to monitor his safety at all times." There was also no documented evidence that the psychologist was informed of or consulted regarding the incident. On the same date at 4:15 p.m., review of the first quarterly psychology review dated October 2010 revealed "0" incidents of food snatching from July through October 2010. The quarterly also failed to reveal knowledge of the August 6, 2010 incident (taking food/snacks/drinks) or that the behavior specialist and/or the psychologist were informed. The second psychology quarterly dated January 2011 stated, "Some data was not available for this review. Further record review revealed there was no QIDP monthly summary	W 159			

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W 159	<p>Continued From page 5</p> <p>documented for January 2011. There was no evidence the QIDP effectively coordinated services to address the client's behavioral needs.</p> <p>2. The QIDP failed to coordinate services to ensure the protocol identified in Client #1's BSP described the dimensions of the cloths he was to be provided to suck.</p> <p>Client #1 was observed on April 27, 2011, at 9:33 a.m., to pull a white round object from his mouth, which was approximately 3/4 inch in diameter. The medication nurse identified the object as cloth and explained that if the client was not given the cloth, he would tear his shirt. Upon returning to the medication room about two minutes later, the client was observed with two pieces of wet cloth in his hand that were approximately 1" wide and 4" long. He was observed pulling the cloth from his mouth, then holding it in his hand.</p> <p>On April 27, 2011 at approximately 9:50 a.m., the licensed practical nurse (LPN) and the QIDP revealed that Client #1 sometimes chewed on cloth. Further discussion with the QIDP indicated that a protocol for cloth sucking had been included in the client's BSP dated July 23, 2011; however, the protocol was discontinued in is revised BSP dated April 12, 2011.</p> <p>Review of the April 12th BSP confirmed the cloth sucking was no longer a target behavior and reviewed the following:</p> <p>Client #1 target behaviors included cloth tearing with the object to reduce incidents of taring paper to zero incident for six month. The BSP required the staff to encourage client to give the paper</p>	W 159	W159.2	4/28/11	

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W 159	Continued From page 6 and/or take clothing out of his mouth. Invite him to participate in an activity involving the use of his hands. If the client continues to attempt to tear paper and/or suck on clothing, staff should offer a piece of cloth from the box with cloth pieces. The QIDP failed to ensure that safety precautions were include in the BSP to address the size/diameter of the cloth provided to the client to suck/chew. 3. [Cross refer to W120.] The QIDP failed to ensure that outside services met the need of Client #3. 4. The QIDP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. (See W189) 5 The QIDP failed to ensure that clients received continuous active treatment, consisting of needed interventions and services. (See W249)			W 159			
					W159.3		6/7/11
					See W120		
					W159.4		6/9/11
					See W189		
					W159.5		5/7/11
					See W249		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was provided training to perform his or her duties effectively, efficiently, and competently for three of three clients in the sample. (Clients #1, #2, and			W 189			

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W 189	Continued From page 7 #3) The findings include: 1. [Cross refer to W455]. The facility failed to ensure that each staff was effectively trained on infection control measures to manage Client #1's cloth sucking behavior. 2. [Cross refer to W252]. The facility failed to ensure staff were trained to document Client #1, #2, and #3's program plan objectives in measurable terms.	W 189	W189.1 On May 3, 2011 the LPN Coordinator in-serviced the residential staff on Infection Control. During this in-service, staff received information related to hand hygiene and preventing contamination. On June 9, 2011 the residential staff received an additional in-service on Infection Control and Universal Precautions. In an effort to ensure that staff supervising individuals are effectively trained on Infection Control, residential staff will be in-serviced on an on-going basis.	6/9/11	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff was effectively trained to implement a client's behavior support plan (BSP), for one of three clients in the sample. (Client #1) The finding includes: 1. The facility failed to ensure staff supervising Client #1 were effectively trained to implement his behavior support plan (BSP). On April 27, 2011 at 7:02 p.m., Client #1 was observed seated on the couch quietly with his legs crossed. At 7:05 p.m., a staff carrying a basket of laundry was observed with a narrow piece of white cloth in his hand. When the client	W 193	W189.2 The QIDP will schedule ongoing documentation training within the residential facility as well as at the Day Program to ensure that the staff is trained on documenting program plan objectives in measurable terms. The residential staffs were in-serviced on May 7, 2011 regarding program plan documentation and implementation. The residential staffs are scheduled to receive an additional program plan	6/15/11	

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W 193	Continued From page 8 held out his hand to get the cloth, the staff then pulled the cloth back and did not give it to the client. The client was not observed to be agitated either before or after he was offered the cloth. Interview with staff on April 28, 2011, at 4:52 p.m. revealed that the Client #2 should only be offered the cloth to suck if he is agitated and can not be redirected. Interview with the QIDP on April 29, 2011 at 2:50 p.m. indicated that all staff had received training on the client's behavior support plan. Record review on April 28, 2011 at 3:50 p.m., revealed the client had BSP dated April 12, 2011 to address his targeted behaviors, which included "tearing paper." The objective stated that [Client] will decrease incidents of tearing paper to 0 incidents per month for 6 months. The BSP also stated that if the client begins to tear paper or suck on his clothes, staff should encourage him to give them the paper and/or take the clothing out of his mouth. If [client] continues to tear paper and/or suck on clothing, staff should invite him to select a piece of cloth from the box with cloth pieces. There was no evidence the staff had implemented the client's BSP as written, which required that he be only offered a piece of cloth if he can not be redirected.	W 193	documentation training on June 15, 2011. In an effort to ensure that staff supervising individuals are effectively trained on program plan implementation/documentation, residential staff will be in-serviced on an on-going basis. W193 On April 28, 2011, Client #1's Behavior Support Plan was amended to eliminate the use of the cloth strips. The QIDP provided an in-service to the Day Program staff as well as Residential Staff regarding the updated Behavior Support Plan on April 28, 2011. On May 7, 2011 provided an additional in-service training on Client #1's Behavior Support Plan.	4/28/11	
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that each	W 220			

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W 220	<p>Continued From page 9</p> <p>client received a speech and language development assessment, as recommended for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On April 27, 2011 at 8:27 a.m., Client #1 was observed sitting quietly in the living room as staff talked to him, however, did not respond verbally. Staff indicated that the client was unable to talk.</p> <p>During the entrance conference on April 27, 2011, at 9:45 a.m., the qualified intellectual disability professional (QIDP) revealed that Client #1 was admitted to the facility on July 16, 2010, from another agency. At 2:37 p.m., the QIDP acknowledged that the client's speech and language language development had not been formally assessed after his admission.</p> <p>On April 28, 2011 at 4:25 p.m., the review of the client's annual psychological assessment dated April 10, 2011, revealed, "It appears that the client's receptive skills are stronger than his expressive capabilities; some of the targeted behaviors may be expressions of frustration with his difficulties with communication." The psychologist recommended to refer to the speech and language therapy report for further information. The QIDP indicated that the speech pathologist and been requested to assess the client.</p> <p>On April 27, 2011 at 2:17 p.m., review of Client #1's audiology assessment dated January 10, 2009, revealed he had a chronic abnormal middle ear function bilaterally. Review of Client #1's occupational therapy assessment dated February</p>	W 220	W220 Innovative Life Solutions will continue to ensure that all individuals receive a speech and language development assessment. On April 30, 2011, Client #1 was assessed and evaluated by the Speech Pathologist. ILS will continue to ensure that adequate an appropriate communication is provide to ensure that consultant are provided with adequate time to ensure that assessments can be completed in appropriate and timely manner	4/30/11	

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W 220	Continued From page 10 15, 2011, revealed "hearing and speech impairment. ..." There was no evidence, however, that his receptive and expressive language skills had been assessed to determine his specific communication needs.	W 220		6/15/11	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train all clients in personal skills (communication) essential for independence, for one of three clients in the sample. (Client #1) The finding includes: [Cross refer to W220]. Interview with the qualified intellectual disability professional (QIDP) on April 27, 2011 at 1:50 p.m., revealed Client #1's individual program plan (IPP) did not include training to improve his communication skills. On April 28, 2011, at 4:20 p.m., review of Client #1's behavior support plan (BSP) dated April 12, 2011 implemented at his group home revealed the client may initiate interactions with others by	W 242	W242 Innovative Life Solutions will ensure that all clients are trained in personal skills essential for independence. On June 10, 2011, Client #1 and his staff were in-serviced on Client #1's method of communication and appropriate responses to Client #1's communication efforts. On June 15, 2011 the residential staff will receive an additional in-service on Client #1's communication. The QIDP will develop a program plan objective related to Client #1's communication needs.		

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W 242	Continued From page 11 pulling on one's arm to communicate his needs. Continued review of the BSP revealed it included a targeted behavior of grabbing. On April 29, 2011 at 11:30 a.m., review of Client #1's updated behavior support plan (BSP) at his day program dated April 26, 2011, revealed the client frequently touches and grabs others, the grabbing seems to have a primary communicative function..... A similar pattern of the use of grabbing as communication is noted at his residence. Consequently, grabbing is being discontinued as a target." At the time of the survey, however, there was no evidence the client was receiving training to improve his communication skills.	W 242			
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, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations, for two of three clients in the sample. (Clients #2, and #3) The findings include:	W 249			

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W 249	Continued From page 12 1. The facility failed to provide one-on-one supervision for Client #3 to prevent falls (ambulation protocol/behavior support plan), as evidenced below: On April 28, 2011, at approximately 9:00 a.m., the surveyor heard a noise. Client #3 was observed lying on the floor, and his helmet was on the floor behind him. Further observation at that time revealed the client's one on one staff was in directly in front of him, then immediately turned around and walked to the client to assist him to his feet. Seconds later, the licensed practical nurse (LPN) walked into the room and began to assess the client. Interview with the nurse revealed she wanted to make sure the client was "fine". Interview with the staff on April 29, 2011, at approximately 9:10 a.m., indicated that the client lays on the floor, as he sometimes does. On April 29, 2011 at 10:32 a.m., review of Client #3's BSP dated April 13, 2011, revealed interventions to address self injurious behaviors (SIBs), which included intentionally falling to the ground. Interventions identified in the BSP to prevent the behavior included a one to one staff "to closely monitor him for any indicators of this, and intervene as early in the cycle as possible." Further review revealed "staff should make attempts to have a small pillow (or other soft objects, such as a jacket) nearby so that, if he begins to bang his head, staff may cushion his head with the pillow. If a soft object is not available, staff may also use their hands to help cushion [the client's] head.	W 249	W249.1 Innovative Life Solutions will ensure continuous active treatment is implemented in accordance with the interdisciplinary team. The Psychologist will review the Behavior Support Plan to assess appropriateness of the intervention strategies. On May 3, 2011, the residential staff received an in-service on one to one protocol as well as Client #3's helmet throwing behavior and documentation. On May 7, 2011, the residential staffs were in-serviced on BSP implementation.	5/7/11	

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W 249	<p>Continued From page 13</p> <p>On April 29, 2011, at 10:51 a.m., review of Client #3's physical therapy assessment revealed staff is required to "provide contact guard assistance when he is mobile and provide standby assistance at all times for safety".</p> <p>The facility failed to ensure that the staff implemented the client's BSP and physical therapy protocol as written.</p> <p>2. The facility failed to ensure Client #3's communication objective was implemented, as evidenced below:</p> <p>On April 27, 2011 (8:35 a.m. , 4:15 p.m.) and April 28, 2011 (11:38 a.m.), Client #3's one-on-one staff was observed questioning him about his personal needs and daily activities. The clients speech was mumbled and repetitive.</p> <p>Record review on April 29, 2011, at 11:30 a.m., revealed that on April 11, 2010, the speech and language pathologist recommended that the client receive formal communication programming using a low tech voice output communication device (personal talker).</p> <p>Interview with the QIDP on April 29, 2011, at approximately 2:15 p.m., revealed that a low tech voice output communication device had not been provided for the client after she was employed by the facility, approximately eight months prior to the survey. The facility failed to ensure continuous active treatment as recommended to improve his communication skills.</p> <p>[Note: Review of the program data revealed that</p>			W 249	<p>W249.2</p> <p>On May 10, 2011 the Speech and Language Therapist completed consultant note requesting that the program objective related to using a communication device is discontinued. According to the Speech and Language Therapist, Client #3 appears to have maximized his ability to complete tasks related to this program objective. The residential staffs were in-serviced on May 7, 2011 regarding program plan documentation and implementation. The residential staffs are scheduled to receive an additional program plan documentation training on June 15, 2011. In an effort to ensure that staff supervising individuals are effectively trained on program plan implementation/documentation, residential staff will be in-serviced on an on-going basis</p>		6/15/11

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W 249	Continued From page 14 the objective was being implemented.]	W 249			
	3. The facility failed to ensure that Client #3's day program goal to improve his activity of daily living skills was consistently implemented at his day program by his one on one staff. (See W120)		W249.3 See W120		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on the individual program plan for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. Observation on April 27, 2011, at 5:06 p.m., revealed Client #2 biting his hand as he sat at the dining room table. The facility coordinator stated the client becomes agitated when people are around him. At 7:07 p.m., Client #2 bit his hand again as he sat in the living room. On April 28, 2011, at 9:30 a.m., review of Client #2's BSP, dated April 13, 2011, confirmed that biting himself is one of his primary targeted maladaptive behaviors. The BSP also instructed staff to document each of the behaviors on the "data sheets". On April 28, 2011, at 10:05 a.m., review of the client's behavior data sheets for	W 252	W252.1 Innovative Life Solutions will ensure consisted documentation of progress on the individual program plan for all individuals. On May 7, 2011, the residential staff was in-serviced on BSP implementation. The residential staffs are scheduled to receive an additional BSP implementation and documentation training on June 15, 2011. In an effort to ensure that staff supervising individuals are effectively trained on BSP implementation/documentation, residential staff will be in-serviced on an on-going basis.	6/15/11	

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W 252	<p>Continued From page 15</p> <p>April 27, 2011, revealed the staff failed to document each time Client #2 displayed his maladaptive behavior (biting himself).</p> <p>In an interview with the qualified developmental disability professional (QIDP) on April 29, 2011, at 10:15 a.m., it was acknowledged that the direct support staff is required to document all target maladaptive behaviors.</p> <p>The facility failed to evidence that Client #2's primary targeted maladaptive behaviors were documented as required by the psychologist.</p> <p>2. Observation on April 27, 2011, at 9:15 a.m., revealed Client #3 threw his helmet down. On April 28, 2011 at approximately 4:30 p.m., the surveyor heard a loud noise. Interview with the (QIDP) revealed Client #3 threw his helmet.</p> <p>On April 29, 2011, at 10:32 a.m., review of Client #3's BSP, dated April 13, 2011, confirmed that throwing his helmet is one of his primary targeted maladaptive behaviors. The BSP also instructed staff to document each of the behaviors on the "data sheets". On April 29, 2011, at 9:00 a.m., review of the client's behavior data sheets for April 27, 2011, and April 28, 2011, revealed the staff had failed to document each time Client #2 displayed his maladaptive behaviors.</p> <p>In an interview with the QIDP on April 29, 2011, at 10:15 a.m., it was acknowledged that the direct support staff is required to document all target maladaptive behaviors.</p> <p>The facility failed to evidence that Client #3's primary targeted maladaptive behaviors were</p>	W 252	<p>W252.2</p> <p>On May 3, 2011, the residential staff received an in-service on one to one protocol as well as Client #3's helmet throwing behavior and documentation. On May 7, 2011, the residential staffs were in-serviced on BSP implementation.</p>	5/7/11	

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W 252	Continued From page 16 documented as required by the psychologist. 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been reviewed and approved by the Human Rights Committee (HRC), for two of three clients in the sample. (Clients #2, and #3) The findings include: 1. Observations during the medication administration, on April 27, 2011, at 8:45 a.m., revealed that Client #2 received Ativan, Hydroxyzine, Chlorpromazine and Depakote. Interview with the Licensed Practical Nurse (LPN) during the medication administration indicated that the client received the medications for maladaptive behaviors. Interview with the qualified intellectual disability professional (QIDP) and the review of Client #2's record on April 28, 2011, at 9:30 a.m., revealed the client's behavior support plan (BSP) addressed his targeted behaviors. Review of the BSP dated April 13, 2011, confirmed that it addressed his maladaptive behaviors of property destruction, physical aggression and self-injurious	W 252		4/28/11	
W 262		W 262			

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W 262	<p>Continued From page 17</p> <p>behavior. The review of the HRC minutes on April 29, 2011, at 11:48 a.m., revealed that the use of the psychotropic medications was reviewed and approved, however the dosages of the medications were not documented in the minutes. The LPN confirmed that the HRC minutes failed to evidence that the HRC reviewed the amount of medication prescribed.</p> <p>2. Observations during the medication administration, on April 27, 2011, at 9:20 a.m., revealed that Client #3 received Benadryl, Lorazepam, Lithium and Risperdal. Interview with the Licensed Practical Nurse (LPN) during the medication administration indicated that the client received the medications for maladaptive behaviors.</p> <p>Interview with the QIDP and the review of Client #3's record on April 29, 2011, at 10:32 a.m., revealed the client had a behavior support plan (BSP) to address his targeted behaviors. Further review of the BSP dated April 13, 2011 confirmed that it addressed his maladaptive behaviors of physical aggression, self-injurious behavior, tantrumming, and disrobing. The review of the HRC minutes on April 29, 2011, at 12:05 p.m., revealed that Risperidone and Benadryl was reviewed and approved, however the dosage of the medications were not documented in the minutes. Additionally, the HRC minutes revealed no evidence that Lithium, Lorazepam and Risperdal were reviewed and approved by the HRC.</p> <p>The facility failed to review and approve the client's current psychotropic medications as prescribed.</p>	W 262	<p>W262.2</p> <p>See W262.1</p>	

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W 262	Continued From page 18 3. On April 28, 2011, at approximately 4:00 p.m., Client #2 was observed wearing a gait belt. Interview with the LPN and the QIDP acknowledged that the HRC had not approved the use of the gait belt for the client. On the same day at 3:34 p.m., review of the physical therapy assessment dated March 15, 2011, revealed a recommendation for the use of a gait belt. At approximately 4:30 p.m., interview with the LPN and the QIDP acknowledged that the HRC had not approved the use of the gait belt for the client.	W 262	W262.3 On April 15, 2011, the Human Rights Committee reviewed the use of the gait belt for Client #2. The Human Rights Committee Chairperson signed and agreed to the use of the gait belt. HRC will convene at least quarterly to ensure approval of all restrictive controls.	4/28/11	
W 263	There was no evidence that the use of the gait belt was reviewed and approved by the HRC. 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consent, for one of the three clients in the sample. [Client #2] The finding includes: 1. [Cross refer to W262.1] On April 28, 2011, at 9:30 a.m., review of Client #2's BSP, dated April 13, 2011, revealed interventions to address	W 263	W263.1 Innovative Life Solutions will ensure that restrictive measures are reviewed and approved by the Human Rights Committee for all individuals. The QIDP has made several attempts to contact the guardian for Client #2 with no success. The QIDP notified the Service Coordinator for Client #2 of her attempts to contact the guardian. The Service Coordinator discovered that the guardian is presently located in a Nursing Home and unable to sign documentation for Client #2. The Service Coordinator is making attempts to locate a different guardian for Client #2.	4/28/11	

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W 263	Continued From page 19 maladaptive behaviors of property destruction, physical aggression and self-injurious behaviors. The review of the HRC minutes on April 29, 2011, at 11:48 a.m., revealed that the BSP was reviewed and approved. At the time of the survey, however there was no evidence that the client's guardian consented to the implementation of the BSP. 2. [Cross refer to W262.3] The facility failed to ensure written consent was obtained from client #2's guardian prior to the implementation of restrictive measures (gait belt).	W 263	W263.2 See W263.1		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain medication administration records (MAR) to document the administration of medications for one of three clients in the sample. (Client #2) The findings include: Observation of the medication administration on April 27, 2011, at 8:45 a.m., revealed Client #2 was administered Ativan, Vitamin E, Vitamin C, Hydroxyzine, Chlorpromazine, Trihexyphenidyl, Calcium, Depakote and Lisinopril. On the same day, at 10:00 a.m., review of Client #2's medication administration record (MAR) dated April 1, 2011, revealed that the client was prescribed Fosamax. Review of the physician's	W 365	W365 On May 10, 2011, the RN Supervisor provided training to the LPN Coordinator that included medication administration, securing medications, hand hygiene and disposal of medications. Medication administration training for all of the nurses working with Innovative Life Solutions has been scheduled for June 15, 2011. LPN coordinator received a disciplinary action for failing to ensure that medications are given as per Physician Order Sheet.	6/15/11	

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W 365	Continued From page 20 order dated April 1, 2011, confirmed that the client was prescribed "Alendronate (Fosamax) 70 mg, take one tablet weekly by mouth." Further review of the MAR, however, revealed no documented evidence that Fosamax had been administered during the month of April 2011. On April 27, 2011, at 10:20 a.m., further observation of Client #2's April 2011 medications revealed the weekly dosages of Fosamax had been removed from the medication card. Interview with the nurse on April 27, 2011, at 10:25 a.m., revealed she had administered Client #2's Fosamax one day a week as prescribed. The nurse acknowledged, however, that she failed to document administration of this medication. There was no evidence that the nurse ensured that the client's medication administration record was accurately maintained.	W 365			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered without error, for three of the five clients residing in the facility. (Clients #1, #2 and #5) The findings include: 1. Observation of the medication administration on April 27, 2011, at 8:45 a.m., revealed Client #2	W 369	W369 See W365		

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W 369	<p>Continued From page 21</p> <p>was administered Ativan, Vitamin E, Vitamin C, Hydroxyzine, Chlorpromazine, Trihexyphenidyl, Calcium, Depakote and Lisinopril. On the same day, at 10:00 a.m., review of the client's medication administration record (MAR) and current physician orders, revealed that Fosamax, Patanol, Nasonex, Saline Nasal Spray and Astepro were ordered, but not administered during the morning medication pass.</p> <p>Interview with the nurse on April 27, 2011, at 10:25 a.m., revealed that Patanol, Nasonex and the Saline Nasal spray were not available. The nurse also indicated that Astepro was not offered to the client because he had refused it for the last three days. The MAR, however, failed to document why the client did not receive his prescribed medications. On April 27, 2011, at 3:55 p.m., the LPN informed the primary care physician (PCP) that the client did not receive his Fosamax as prescribed. As a result, the primary care physician informed the LPN to administer the Fosamax when the client arrived home from the day program.</p> <p>2. On April 27, 2011, at 9:33 a.m., Client #1 was administered Maxzide, Carbidoplevo 25/100 mg, Therobec Plus and two drops of ear wax removal. During this time, the LPN poured Polyethylene Glycol G 3350 NF into the medication bottle cap, mixed it with water, then administer it to the client.</p> <p>On the same day at 10:08 a.m., review of Client #1's current MAR and the physician orders, revealed that artificial tears was ordered, but not given. The client's MAR and the physician's orders dated April 1, 2011, also revealed that</p>	W 369			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G212	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2011
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012		
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W 369	Continued From page 22 three drops of ear wax removal was prescribed, instead of the two drops of ear wax removal administered. Additionally, the Polyethylene Glycol measuring cup provided by the manufacturer to measure the medication was not used by the nurse. Interview with the nurse on April 27, 2011, at 10:30 a.m., confirmed that the cap of the Polyethylene Glycol was not the same measurement as the prescribed measuring cup. Additional interview revealed that she applied two drops of ear wax removal instead of three. The LPN also revealed that the artificial tears was not available, however, at 4:09 p.m., the LPN stated the artificial tears was delivered and that the client would receive it during the evening medication administration. 3. Observation of the medication administration on April 27, 2011, at 9:00 a.m., revealed Client #5 was administered Calcium, Allegra, Saline Nasal Spray and Antihistamine. On the same day, at 10:20 a.m., review of the client's medication administration record (MAR) and the physician orders dated April 1, 2011, revealed that one drop of Saline Nasal Spray was administered instead of two drops. Interview with the LPN on April 27, 2011, at 10:30 a.m., revealed that she administered one drop instead of two drops as prescribed.	W 369			
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications	W 371			

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W 371	<p>Continued From page 23</p> <p>is an appropriate objective, and if the physician does not specify otherwise.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for three of three clients in the sample. (Clients #1, #2, # and #3)</p> <p>The findings include:</p> <p>1. Observation on April 27, 2011, at 8:45 a.m., revealed Client #2 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the client's medications from his bubble packs. Continued observation revealed the LPN mixed the client's medication with applesauce and spoon fed/administered the client his medications. After the client swallowed his medications, the LPN handed him a cup of water, then placed the cup on the table.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated April 1, 2011, on April 27, 2011, at 12:00 p.m., revealed a program objective which stated, "given verbal prompts [the client] will put his medications in his mouth when handed over by the nurse on 60% of the opportunities per month across six consecutive months." Further review indicated Client #2's self-medication program was outlined as follows:</p> <ul style="list-style-type: none"> - lift his medication cup to his mouth; - throw his cup in trash; 	W 371	<p>W371.1</p> <p>Innovative Life Solutions will ensure that an effective system is implemented to ensure that each individual participates in a self-medication training program for all individuals. Client #2 was re-evaluated for the appropriateness of the self-medication plan. The self-medication plan was modified according to Client #2's ability to place medication in his mouth with assistance if needed.</p>	4/30/11	

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W 371	Continued From page 24 Review of Client #2's program documentation record on April 27, 2011, at approximately 12:15 p.m., indicated that the client participated in his self medication program. Interview with the LPN, however, confirmed that Client #2's self-medication objective was not implemented. 2. Observation on April 27, 2011, at 9:20 a.m., revealed Client #3 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the client's medications from his bubble packs. Continued observation revealed the LPN mixed the client's medication with applesauce and spoon fed/administered the client his medications. After the client swallowed his medications, the LPN handed him a cup of water then placed the cup on the table. Review of Client #3's Individual Program Plan (IPP) dated April 1, 2011, on April 27, 2011 at 12:20 p.m., revealed a program objective which stated, "given verbal prompts [the client] will put his medications in his mouth when handed over by the nurse on 60% of the opportunities per month across six consecutive months." Further review indicated Client #3's self-medication program was outlined as follows: - lift his medication cup to his mouth; - throw his cup in trash; Review of Client #3's program documentation record on April 27, 2011, at approximately 12:25 p.m., indicated that the client participated in his self medication program. Interview with the LPN, however, confirmed that Client #3's	W 371	W371.2 Innovative Life Solutions will ensure that an effective system is implemented to ensure that each individual participates in a self-medication training program for all individuals. Client #3 was re-evaluated for the appropriateness of the self-medication plan. The self-medication plan was modified according to Client #3's ability to independently drink water after taking his medication, with assistance as needed.	4/30/11	

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W 371	Continued From page 25 self-medication objective was not implemented. 3. Observation on April 27, 2011, at 9:33 a.m., revealed Client #1 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the client's medications from his bubble packs. Continued observation revealed the LPN mixed the client's medication with applesauce and spoon fed/administered the client his medications. After the client swallowed his medications, the LPN handed him a cup of water then placed the cup on the table. Review of Client #1's Individual Program Plan (IPP) dated April 1, 2011, on April 27, 2011 at 12:38 p.m., revealed a program objective which stated, "given verbal prompts [the client] will put his medications in his mouth when handed over by the nurse on 60% of the opportunities per month across six consecutive months." Further review indicated Client #1's self-medication program was outlined as follows: - lift his medication cup to his mouth; - throw his cup in trash; Review of Client #1's program documentation record on April 27, 2011, at approximately 12:42 p.m., indicated that the client participated in his self medication program. Interview with the LPN, however, confirmed that Client #1's self-medication objective was not implemented.	W 371	W371.3 Innovative Life Solutions will ensure that an effective system is implemented to ensure that each individual participates in a self-medication training program for all individuals. Client #1 was re-evaluated for the appropriateness of the self-medication plan. The self-medication plan was modified according to Client #1's ability to independently drink water after taking his medication, with assistance as needed.	4/30/11	
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper	W 381			

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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOULTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7418 BLAIR ROAD, NW WASHINGTON, DC 20012		
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W 381	Continued From page 26 conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security, for five of five clients residing in the facility. (Client #1, #2, #3, #4 and #5) The finding includes: During the medication administration on April 27, 2011, at 9:23 a.m., and at 9:40 a.m., the license practical nurse (LPN) was observed to leave medications on the table and to leave the medication closet door open as she left the room to wash her hands. Continued observation revealed the qualified intellectual disability professional (QIDP) and the house manager were sitting in the same room. In an interview on April 27, 2011, at 10:30 a.m., the LPN stated "i asked the QIDP or the house manager to watch the medications." The LPN failed to evidence that all drugs were stored under proper conditions of security.	W 381	W381 See W365		
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 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.	W 436			

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W 436	<p>Continued From page 27</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide and maintain in good repair adaptive devices recommended by the interdisciplinary team, for one of three clients in the sample. (Client #3)</p> <p>The finding include:</p> <p>1. The facility failed to ensure Client #3's protective helmet was maintained in good repair, as evidenced below:</p> <p>On April 27, 2011, at 8:47 a.m., Client #3 removed his protective helmet from his head several times and threw it on the floor. He was verbally prompted by his one on one staff to put the helmet back on his head. Further observation of the helmet at 8:57 a.m. revealed that a piece was missing from the left side, and that the chin strap could not be secured. Later that morning at 9:15 a.m., the client's protective helmet fell off his head as he scooted forward in his chair to receive his medications.</p> <p>Interview with direct care staff on April 27, 2011, at 8:59 a.m., revealed that Client #3 was "hard on helmets" and had received a new helmet several months prior to the survey. Interview with the qualified intellectual developmental professional (QIDP) at 9:45 a.m., revealed the staff had just informed her that the strap broke off the client's helmet earlier that morning. Further discussion with the QIDP revealed that damage was initially observed on the helmet a couple of weeks before the survey. At 10:20 a.m., the primary licensed practical nurse (LPN) and the QIDP stated that the client was measured for a new helmet at his</p>	W 436	<p>W436.1</p> <p>According to the Adaptive Equipment Request Tracking Form documented by the QIDP on April 19, 2011 a soft helmet was approved and ordered for Client #3. On May 3, 2011 the QIDP called the RN Supervisor to inquire about the status of the soft helmet. The RN Supervisor submitted a medical necessity and will order a hard helmet as well. On May 6, 2011 the hard helmet for Client #3 was received and provided. On June 7, 2011, the QIDP notified the RN Supervisor to inquire about the status of the soft helmet for Client #3. The RN Supervisor will notify the vendor to follow up on the status of the helmet. Client #3 will continue to wear the hard helmet that he was provided on May 6, 2011.</p>	5/7/11

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W 436	<p>Continued From page 28</p> <p>day program on April 23, 2011. Discussion with the day program director on April 28, 2011 (11:38 a.m.), indicated that the client's helmet had been damaged for approximately one month.</p> <p>On April 29, 2011, at 5:10 p.m., continued record review revealed a nursing progress note dated January 5, 2011 which stated that Client #3's helmet was still on order. A consultation report dated October 4, 2011 had revealed, "Re: Helmet replacement; current helmet broken/worn beyond repair. The attached 719A requisition form dated November 30, 2010, stated, "Purchase a new protective hard shell helmet," was attached to the consultation. The review of the client's ongoing and current physician's order dated April 1, 2011, revealed a "Helmet w/face guard" was prescribed due to gait instability and history of falls and head injury. At the time of the survey, there was no evidence that Client #3's protective helmets were furnished timely and maintained in functional condition.</p> <p>2. The facility failed to ensure a communication device (personal talker) recommended by the IDT for Client #3 was provided, as evidenced below:</p> <p>On April 27, 2011 (8:35 a.m. , 4:15 p.m.) and April 28, 2011 (11:38 a.m.), Client #3's one-on-one staff was observed questioning him about his personal needs and daily activities.</p> <p>Interview with the QIDP on April 29, 2011, at approximately 2:15 p.m., revealed that a low tech voice output communication device had not been provided for the client after she was employed by the facility, approximately eight months prior to the survey.</p>	W 436	<p>W436.2</p> <p>SeeW249.2</p>		

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W 436	Continued From page 29	W 436		
W 455	Record review on April 29, 2011, at 11:30 a.m., revealed that on April 11, 2010, the speech and language pathologist recommended that the client receive formal communication programming, using a low tech voice output communication device (personal talker). 483.470(I)(1) INFECTION CONTROL 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 interview, the facility failed to ensure that procedures for prevention of communicable disease were implemented for one of the three clients in the sample. (Client #1) The finding includes: Observation of Client #1 on April 27, 2011, at 8:30 a.m., revealed the client sat quietly in the living room continuously chewing. On the same morning at 9:30 a.m., the staff escorted the client to the office to receive his medications. After verbal prompting from the nurse, he removed an object from his mouth with his hand, then put it back again. The object was later identified by the nurse as a piece of cloth. As the client pulled the piece of cloth from his mouth, it appeared to measure approximately 1" in width and 4" in length. After taking his medications, he was observed with two pieces of clothes in his hand. A staff wearing gloves escorted the the client directly to board the van. Staff was not, however, observed to wash the client's hands after he	W 455 W455 See W189.1		

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455	Continued From page 30 handled the wet cloths. Interview with the QIDP on April 28, 2011, at approximately 4:20 p.m. indicated that staff were trained to implement sanitary measures when Client #1 removed the wet cloth from his mouth. On April 28, 2011 at 4:25 p.m., the review of Client #1's BSP dated April 12 2011, however, revealed it failed to identify infection control measures to address the client's removal of the wet cloth from his mouth. At the time of the survey, the facility failed to evidence effective infection control procedures were implemented for the client.	W 455			

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 04/29/2011
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1000	INITIAL COMMENTS A licensure survey was conducted from April 27, 2011, through April 29, 2011. A random sample of three residents was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.	1000		
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure the environment was maintained in a safe, clean and orderly manner to meet the needs of five of five residents in the facility. (Residents #1, #2, #3, #4, and #5) The findings include: During the environmental walk-through on April 29, 2011, at approximately 5:02 p.m., the surveyor was accompanied by the administrator and the qualified intellectual disability professional (QIDP) to conduct observations. The following concerns were identified: 1. The gutters installed at the front of the house were not secured tightly on both the right and left ends.	1090	1090.1 Innovative Life Solutions will ensure the envirohment is maintained in a safe, clean and orderly manner to meet the needs of all of the individuals. Innovative Life Solutions has a maintenance service contract to review and address maintenance issues. On April 30, 2011 the gutters were secured tightly on both the right and left ends.	4/30/11

Health Regulation Administration

TITLE

(X5) DATE

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

STATE FORM

6689

CDGQ11

If continuation sheet 1 of 14

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 04/29/2011
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I 090	Continued From page 1 2. On the porch exiting from the bedroom of Residents #3 and #5, the following concerns were noted: a. One piece of the railing was not secured at the base. b. A raised, split, warped board with a protruding nail head. c. Splinters on the railing 3. Open sockets were observed in the floor lamp in the bedroom of Residents #1 and #2. Burned out light bulbs were observed in the floor lamp in the bedroom of Residents #3 and #5, and in the range hood. Upon notification of the light bulbs, they were replaced by the facility. There was no evidence an effective system had been implemented to ensure adequate lighting in the aforementioned areas.	I 090	1090.2 Innovative Life Solutions will ensure the environment is maintained in a safe, clean and orderly manner to meet the needs of all of the individuals. Innovative Life Solutions has a maintenance service contract to review and address maintenance issues. On April 30, 2011 the railing on the porch of residents #3 and #5 was secured. The warped board with protruding nail head was replaced on April 30, 2011 as well. The splinters on the railing were also removed on April 30, 2011.	4/30/11	
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure adequate administrative support to meet the habilitation needs of three of three residents in the sample. (Residents #1 #2 and #3) The findings include: [Cross refer to Federal Deficiency Report -	I 180	1090.3 An environmental check list has been created as an effective means of addressing all environmental issues within the facility. This check list will be completed monthly and reported for repair.	5/7/11	

Health Regulation Administration

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I 180	Continued From page 2 Citation W159) 1. The QIDP failed to effectively coordinate and monitor Resident #1's behavior management. 2. The QIDP failed to coordinate services to ensure the protocol identified in Resident #1's BSP described the dimensions of the cloths he was to be provided to suck. 3. [Cross refer to Federal Deficiency Report - Citation W120]. The QIDP failed to ensure that outside services met Resident #3's active treatment needs. 4. The QIDP failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. (See Federal Deficiency Report - Citation W189 and W193) 5. The QIDP failed to ensure that residents received continuous active treatment, consisting of needed interventions and services. (See Federal Deficiency Report - Citations W249)	I 180	1180.1 See W159.1, W159.2 1180.2 See W159.2 1180.3 See W 120 1180.4 See W189.2, W193 1180.5 See W249.1		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on staff interview and record review, the	I 206			

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1206	Continued From page 3 Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure an annual health certificate was provided for three (3) of fifteen staff and four (4) of thirteen consultants contracted to provide professional services. (Staff #1, #2, and #3 and Consultants #1, #2, #3, and #4) The finding includes: On April 28, 2011, at approximately 4:45 p.m., review of the facility's records revealed there were no current health certificates on file for facility Staff #1, #2, and #3. Continued record review on the same day at 5:00 p.m., revealed no current health certificates were on file for Consultants #1, #2, #3, and #4. At 5:20 p.m., the administrative office was notified of the finding. On April 29, 2011 at 4:45 p.m., the administrator acknowledged that current health certificates were not available for the aforementioned individuals.	1206	1206 Innovative Life Solutions will ensure an annual health certificate is provided for all staff working within the facility. Two weeks prior to the expiration of the staff member's health certificate, the administrative staff will notify the QIDP of the upcoming expiration of the staff member's health certificate. One week prior to the expiration of the staff member's health certificate the administrative staff will submit a second notice to the QIDP and will also notify the Human Resources Manager. The staff member will be taken off of the schedule if the health certificate expires and will be unable to return to work until an accurate health certificate is obtained.	4/28/11
1222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHPID failed to ensure each staff was provided continuing training that enabled them to perform their duties effectively, efficiently and competently for three of three residents residing in the GHPID. (Residents #1, #2, and #3) The findings include: [Cross refer to federal deficiency report - Citation W193]. The GHPID failed to ensure each staff	1222	1222.1 See W193	

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I 222	Continued From page 4 was effectively trained on strategies to manage Resident #1's behaviors. 2. [Cross refer to federal deficiency report - Citation W455]. The GHPID failed to ensure that each staff was effectively trained on infection control measures to manage Resident #1's cloth sucking behavior. 3. [Cross refer to federal deficiency report - Citation W252]. The GHPID failed to ensure staff were trained to document Resident #1, #2, and #3's program plan objectives in measurable terms.	I 222	 I222.2 See W189.1 I222.3 See W252.1	
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with intellectual Disability (GHPID) failed to ensure that each record was kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies for one of three residents in the sample.(Resident #2) The finding includes: Record review on April 27, 2011, at 6:21 p.m., revealed the nursing assessments for the first and second quarters were not on file for Resident #2. Interview with the administrator revealed that	I 261	I261 Innovative Life Solutions will ensure that each record is kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies for all of the individuals. The record information will be made available for personnel of authorized regulatory agencies when requested.	4/28/11

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I 261	Continued From page 5 some of the clients' records had been purged and transferred to the main office for storage. At the time of the survey exit, the nursing quarterly review were not provided as required.	I 261			
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to have on file for review, a written agreement or contract, for one of fifteen professionals providing services for three of three residents in the sample. (Residents #1, #2, and #3) The finding includes: Interview with the qualified intellectual disability professional (QIPD) during the entrance conference on April 27, 2011, at 10:02 a.m., revealed that 5/5 residents in the facility have behavior support plans (BSPs) being monitored by the behavior specialist. On April 28, 2011, at approximately 4:40 p.m., the agency's administrator revealed that the licensed psychologist provides oversight to the licensed behavior specialist who conducts assessment and treatment services for the residents, however, rarely needs to visit the facility. Record reviews revealed the following BSPs were being implemented:	I 274	I274 Innovative Life Solutions will ensure that written agreements and/or contracts for professionals providing services are on file for review. The contract and agreement for psychological services has been obtained and is presently maintained in the personnel record.	4/28/11	

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FORM APPROV

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~~1000-INITIAL COMMENTS~~

A licensure survey was conducted from April 27, 2011, through April 29, 2011. A random sample of three residents was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews and a review of records, including unusual incident reports.

1090 3504.1 HOUSEKEEPING

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by:
Based on observation and interview, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure the environment was maintained in a safe, clean and orderly manner to meet the needs of five of five residents in the facility. (Residents #1, #2, #3, #4, and #5)

The findings include:

During the environmental walk-through on April 29, 2011, at approximately 5:02 p.m., the surveyor was accompanied by the administrator and the qualified intellectual disability professional (QIDP) to conduct observations. The following concerns were identified:

1. The gutters installed at the front of the house were not secured tightly on both the right and left ends.

Health Regulation Administration

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

TITLE

(X6) DATE

STATE FORM

6899

CDGQ11

If continuation sheet 1 of

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I 274	Continued From page 6 a. On April 28, 2011, at 9:30 a.m. - Resident #2's BSP dated April 13, 2011 b. On April 29, 2011, at 10:32 a.m. - Resident #3's dated April 13, 2011 c. On April 27, 2011 at 2:35 p.m. - Resident #1's BSP dated April 12, 2011 Continued review of the BSPs of Residents #1, #2, and #3 revealed they were signed by both a behavior specialist and the licensed psychologist. On April 28, 2011, at 4:20 p.m., review of the personnel records of health care professionals, however, revealed no file was available for the psychologist. Additionally, no agreement or contract for the oversight of the psychological services was provided for review prior to the survey exit.	I 274			
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. This Statute is not met as evidenced by: Based on interview and review of incident reports, the group home for persons with intellectual disability (GHPID) failed to notify the Department of Health (DOH), Health Regulation and	I 379	I 379 The Incident Manager attended an in-service provided by The Department of Health and Developmental Disability Services on May 20, 2011 that addressed incident management and reporting requirements. The Incident Manager will continue to receive in-service trainings provided by regulatory agencies to ensure reporting compliance.	5/20/11	

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I 379	<p>Continued From page 7</p> <p>Licensing Administration (HRLA) of an unusual incident or event which substantially interfered with the resident's health, welfare, living arrangements, well-being or in any other way places the resident at risk, by telephone immediately and followed up by written notification within twenty-four (24) hours or the next work day for one of the five residents in the GHPID (Resident #1).</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on April 27, 2011, beginning at 10:05 a.m., revealed that on January 27, 2011, at 4:05 a.m., Resident #1 attempted to use the bathroom that was having repairs. His foot went through the floor, causing a hole in the floor and minor scratches on his right leg. First aid was administered and the bathroom was observed to prevent further injuries.</p> <p>The review of a nursing progress note dated January 27, 2011, at 11:07 a.m., revealed Resident #1 was evaluated after the fall and determined to have skin abrasions on right shin, right knee and outer lower side of foot. A telephone physician's order dated January 27, 2011, revealed "Skin abrasion to right shin, right knee and outer side of foot. Cleanse daily with soap and water and apply Bacitracin ointment until healed."</p> <p>Interview with the administrator on April 29, 2011, at 4:40 p.m., indicated that the January 27, 2011, incident had been reported as a skin tear, however, DOH was notified. He further acknowledged that staff had been interviewed by the agency's incident management coordinator and had provided detailed written statements on how the incident occurred. According to the</p>	I 379			

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I 379	Continued From page 8 administrator, the floor was being replaced in the bathroom and the door should have been secured. Although further investigation revealed that the incident was verbally reported to DOH, there was no evidence that the written incident report was provided.	I 379			
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHPID failed to have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:	I 395			

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I 395	Continued From page 10 license was valid in the District of Columbia, and that she would be notified accordingly. (The surveyors' Post-Exit consultation with the Director of the DC Board of Nursing on May 2, 2011, revealed that the aforementioned nursing license was not valid in the District of Columbia.)	I 395		
I 410	3520.11 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall ensure that when another agency assumes responsibility for services to a resident, a summary of the appropriate record is forwarded to that agency. This Statute is not met as evidenced by: Based on observation, interview and record review the GHPID failed to ensure that the day program forwarded clients medication administration records (MAR) back to the group home for one of three clients in the sample. (Client #2) The finding includes: Interview with the LPN on April 27, 2011, at approximately 10:40 a.m., revealed the day program revealed that Resident #2 is prescribed to receive medications for behavior at his day program. On April 27, 2011, at approximately 10:50 a.m., review of the current physician's orders dated April 1, 2011, revealed Client #2 was prescribed medications to be given at 2:00 p.m. Observation on April 28, 2011, at 1:22 p.m., revealed Resident #2 was administered Ativan 1 mg, Chlorpromazine 75 mg, and Hydroxyzine 75	I 410	I410 The QIDP will schedule a case conference with the Day Program Nursing professionals to ensure that the MAR's are returned to the residential facility upon completion.	6/15/11

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1410	Continued From page 11 mg at his day program. Interview with the day program License Practical Nurse (LPN) at approximately 1:30 p.m., revealed the client's medications and orders were forwarded from the group home. Review of the medical records on April 27, 2011, beginning at 2:30 p.m., revealed that no monthly MARs were on file at the home to verify the administration of the client's 2:00 p.m. weekday medications at his day program. Interview with the LPN on April 29, 2011, at approximately 3:30 p.m., revealed the day program did not return any of the residents MAR's. At the time of the survey, there was no evidence the GHPID ensured appropriate records were provided by the day program, who was delegated the responsibility of administering the client 2:00 p.m. medications on Monday through Friday.	1410			
1420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to evidence each resident was provided with habilitation and training to enable them to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning for three of three residents in the sample. (Residents #1, #2, and #3)	1420			

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1420	Continued From page 12 The findings include: 1. [Cross refer to Federal Deficiency Report -W242]. The GHPID failed to train all residents in personal skills (communication) essential for independence, for Resident #1. 2. [Cross refer to Federal Deficiency Report -W249]. The GHPID failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations, for Residents #2, and #3. 3. [Cross refer to Federal Deficiency Report -W252]. The GHPID failed to ensure consistent documentation of documentation of progress on the individual program plan for Residents #2 and #3.	1420	1420.1 See W242 1420.2 See W249.1 1420.3 See W252.1	
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District laws that govern the care and rights of persons with mental retardation, for five of five residents in the facility. (Residents #1, #2, #3, #4, and#5)	1500		

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I 500	Continued From page 13 The findings include: 1. [See Federal Deficiency Report - Citation W369] - The facility failed to ensure that medications were administered without error, for three of the five residents in the facility (Residents #1 - #5). 2. [See Federal Deficiency Report - Citation W262] - The facility failed to ensure that restrictive measures had been reviewed and approved by the Human Rights Committee (HRC), for Residents #2 and #3). 2. [See Federal Deficiency Report - Citation W263] - The facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consent, for Resident #2.	I 500	1500.1 See W365 1500.2 See W262 1500.3 See W263		