DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAIL SERVICES

PRINTED: 10/08/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G212 B. WING		10	10/03/2013		
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	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	concluded that reve compliance with the governing body, cliand health care set conducted from Se September 9, 2013 to regain compliant conditions of partice observations reveal failed to provide su Client #1's and #5's W186] The follow-to aborted to provide opportunity to attain A second follow-up October 2, 2013 the determine the facilic cited condition-level this survey were bat with direct support, staff, as well as a readministrative recorreports. The survey findings was in substantial coft participation in g client protections, firservices.	an investigation was ealed the facility failed to be in e conditions of participation of ent protections, facility staffing rvices. A follow-up survey was eptember 8, 2013 through a that revealed the facility failed be with the aforementioned ipation. Specifically, alled that one-to-one (1:1) staff pervision in accordance with a individual support plans. [See up survey, therefore, was the facility a second in compliance. I visit was conducted on rough October 3, 2013, to sty's compliance with previously eldeficiencies. The findings of ased on observation, interviews nursing and administrative eview of client and rds, including unusual incident as determined that the facility compliance with the conditions		TITLE		(X6) DATE	

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.

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

TITLE

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(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING 10/03/2013 HFD03-0206 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7416 BLAIR ROAD, NW INNOVATIVE LIFE SOULTIONS, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {1 000} {1 000} INITIAL COMMENTS On July 26, 2013, an investigation was concluded that revealed the facility failed to be in compliance with the conditions of participation of governing body, resident protections, facility staffing and health care services. A follow-up survey was conducted from September 8, 2013 through September 9, 2013 that revealed the facility failed to regain compliance with the aforementioned conditions of participation. Specifically, observations revealed that one-to-one (1:1) staff failed to provide supervision in accordance with Resident #1's and #5's individual support plans. [See W186] The follow-up survey, therefore, was aborted to provide the facility a second opportunity to attain compliance. A second follow-up visit was conducted on October 2, 2013 through October 3, 2013, to determine the facility's compliance with previously cited condition-level deficiencies. The findings of this survey were based on observation, interviews with direct support, nursing and administrative staff, as well as a review of client and administrative records, including unusual incident reports. The survey findings determined that the facility was in substantial compliance with the conditions of participation in governing body, resident protections, facility staffing and health care services and also with the local licensure requirements.

Health Regulation & Licensing Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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TITLE

(X6) DATE

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 09/30/2013 HFD03-0179 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1307 45TH PLACE, SE R C M OF WASHINGTON WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1000 1000 INITIAL COMMENTS A monitoring survey was conducted on September 30, 2013, to verify corrective actions identified in the facility's plan of correction for the environmental deficiencies cited during the August 28, 2013 licensure survey. The findings of the survey were based on observation, interviews and record review. The survey revealed that measures to correct the environmental deficiencies were implemented and a determination was made that the facility is in substantial compliance.

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