

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

PRINTED: 11/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2012
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7425 8TH STREET NW WASHINGTON, DC 20012
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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		
W 130	<p>A recertification survey was conducted from October 16, 2012 to October 18, 2012. A sampling of two clients was selected from a population of three men with varying degrees of intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, two guardians/family members, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the right to privacy during treatment and care of personal needs for one of two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On October 16, 2012, at 4:45 p.m., observation revealed that Clients #1 and #2 shared a bedroom. At 8:05 p.m., Licensed Practical Nurses</p>	W 130		

Received 11/21/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>C. Donald Director of Quality Assurance</i>	TITLE <i>COO</i>	(X9) DATE <i>11/15/12</i>
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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 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 130	Continued From page 1 (LPNs) #2 and #3 were observed treating Client #1's skin ulcer on his left buttock, and changing the dressing. During this time, Client #2 was observed resting in his bed. Interview with LPN #2 on October 16, 2012, at 7:55 p.m., revealed Client #1's ulcer treatment was done in his bed usually at 10:00 a.m. daily. However, the nurse stated that the dressing was also changed at any time that it became wet or soiled. At the time of the survey, there was no evidence the facility had developed a system to ensure that Client #1's right to personal privacy during treatment was not compromised.	W 130	<p>W 130 Innovative Life Solutions will ensure to provide privacy during treatment and personal care.</p> <p>A curtain will be used to maintain privacy during personal care and the curtain was installed on 11/09/12.</p> <p>QIDP has provided in-service training to Nurses and the Staff working at that facility on Protection of Individual Rights on 11/09/12. See attachment #3(b)</p> <p>In future all staff at ILS will ensure to provide privacy and comply with policy.</p>	
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. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that assistive devices were maintained in good repair for two clients of three clients residing in the facility. (Clients #2 and #3) The findings include: 1. The facility failed to ensure Client #2 and #3's shower chair covers were maintained in good	W 436		

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W 436	Continued From page 2 repair.	W 436		
	<p>a. On October 18, 2012, at 1:25 p.m., observation of Client #3's shower chair revealed the cover was torn on the upper right side. The residential director (Staff #2) was present during the observation and indicated that an order would need to be placed for new shower seat cover for the client.</p> <p>On October 18, 2012, at 1:42 p.m., review of Client #3's ongoing physician's orders, and also the current physician's order dated October 1, 2012, revealed he was prescribed to have a shower chair for bathing.</p> <p>At the time of the survey, there was no evidence that the facility maintained Client #3's shower chair in good repair.</p> <p>b. On October 18, 2012, at 1:26 p.m., observation of Client #2's shower chair revealed the threads in the fabric were frayed and worn thin along the right side of the chair. The residential director, (Staff #2) was present during the observation and indicated that an order would need to be placed for new shower seat cover.</p> <p>On October 18, 2012, at 1:45 p.m., review of Client #2's ongoing physician's orders, and also the current physician's order dated October 1, 2012, revealed he was prescribed to have a shower chair for bathing.</p> <p>At the time of the survey, however, there was no evidence that the facility maintained Client #2's shower chair in good repair.</p>		<p>W 436 Innovative Life Solutions will maintain all the adaptive equipment in good condition. Client #3's bed rail pads and shower chair was replaced on 11/7/12.</p> <p>Client #2's shower chair was replaced on 11/7/12</p> <p>Client #2's low tech voice (The no touch talker) was received on 10/31/12 and the staff will be in-serviced by speech and language pathologist on November 13, 2012</p> <p>QIDP has provided in-service training on maintenance and repair of adaptive equipment on 11/09/12.</p> <p>See attachment #3(c)</p> <p>In the future, Registered Nurse and the QIDP will monitor to ensure be in compliance with adaptive equipment policy.</p>	

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W 436	<p>Continued From page 3</p> <p>2. The facility failed to ensure Client #3's bed rail pads were maintained in good repair.</p> <p>On October 18, 2012, at 1:33 p.m., observation of the bed rails pads attached to Client #3's hospital bed revealed the vinyl covering was cracked and worn in numerous places.</p> <p>The residential director (Staff #2) was present during the observation and acknowledged that the bed rail pads were worn.</p> <p>On October 18, 2012, at 1:53 p.m., review of Client #3's ongoing physician's orders, and the current physician's order dated October 1, 2012, revealed he was prescribed to have side rail pads to ensure his safety.</p> <p>3. The facility failed to furnish a communication device for Client #2 as recommended by the speech pathologist.</p> <p>On October 17, 2012, at 11:53 a.m., at the day program, Client #2 was observed smiling and vocalizing when the surveyor said hello. At 12:10 p.m., the day program counselor (Staff #3) asked the client to identify emergency symbols. Continued observation revealed the client was looking around and smiling as Staff #3 waited for a response. When asked, Staff #3 stated he was trying to teach the client to communicate by blinking his eyes.</p> <p>On October 17, 2012, at 4:07 p.m., review of Client #2's speech assessment dated September 3, 2012, revealed a recommendation for a low tech voice output device with sound and volume control.</p>	W 436			

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W 436	Continued From page 4 Interview with the qualified intellectual disabilities professional (Staff #1) on October 18, 2012, at 2:45 p.m., revealed that a communication device was ordered "last week." Further interview and record review at approximately 2:50 p.m., revealed that a request for funds for a "no touch talker" was completed on October 11, 2012.	W 436			

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STATEMENT OF DEFICIENCIES (X1) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2012
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from October 16, 2012 through October 18, 2012. A sampling of two residents was selected from a population of three men with varying degrees of intellectual and developmental disabilities.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, and two guardians/family members, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
1 090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was maintained in a safe and orderly manner for three of three residents in the facility. (Residents #1, #2, and #3)</p> <p>The findings include:</p> <p>On October 18, 2012, beginning at 12:54 p.m., the residential manager (Staff #2) accompanied the surveyor through the facility's environment to</p>	1 090		

Health Regulation & Licensing Administration

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

TITLE

COO

(X6) DATE

11/15/12

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 16., 2012 through October 18, 2012. A sampling of two residents was selected from a population of three men with varying degrees of intellectual and developmental disabilities. The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, nursing and administrative staff, and two guardians/family members, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was maintained in a safe and orderly manner for three of three residents in the facility. (Residents #1, #2, and #3) The findings include: On October 18, 2012, beginning at 12:54 p.m., the residential manager (Staff #2) accompanied the surveyor through the facility's environment to	I 090		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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

FORM

6599

HDD211

If continuation sheet 1 of 5

Health Regulation & Licensing Administration

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I 090	Continued From page 1 conduct observations. The following concerns were identified: A. The facility failed to maintain the exterior environment. 1. Observation of the wheelchair access ramp revealed that it extended from the sidewalk at the front of the facility to the rear exit door of the facility. A gate was observed at the corner of the ramp. When the gate was unlatched and opened, the ground was noted to be approximately six inches below the floor of the ramp, and there was no system in place to transport the residents wheelchairs from the ramp to the ground. Observation of the back yard during this time revealed a partially disintegrated tree stump. Additionally, six long tree roots extended horizontally from the stump and protruded partially above the ground, presenting potential trip hazards. The back yard was equipped with a paved patio area located about four feet from the back of the house, which was approximately 18 feet wide and 12 feet long. Further observation of the back yard revealed it was elevated approximately eight feet above street level and no structure was in place to partition it from the alley below. Interview with Staff #5 at 1:39 p.m., revealed that only the staff went into the back yard as needed. Further discussion with the facility staff revealed that the residents were not taken into the back yard because it was not wheelchair accessible. At the time of the survey, there was no evidence the facility ensured that the back yard was maintained in a manner to ensure its safe	I 090	<p>1090 Innovative Life Solutions will continue to ensure the interior and exterior of the facility are maintained in a safe, clean, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p> <p>Agreement Contract for remodeling of wheelchair access was signed on 11/1/12 for the following list of items.</p> <ul style="list-style-type: none"> • Concrete walkway from the wheelchair access ramp to the patio located in the rear of the house. • Wood fence and a gate in the rear of the existing house from the alley. • Clean up and removal of all debris. <p>See attachment of contract agreement # 1(a) &1(b)</p>	

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I 090	Continued From page 2 accessibility to the residents. 2. The clips required to secure several wires against the exterior wall of the house were noted to be missing, causing them to be partially detached. The maintenance personnel was informed on October 18, 2012, at 3:11 p.m. After checking the wires, the maintenance personnel stated that the wires were possibly cable or telephone wires. He stated that the appropriate utility company would be requested to assess and tighten the wires. B. The facility failed to maintain the interior environment. 1. The protective covering on the gasket installed on the oven was worn, exposing the coils. Additionally, the gasket was partially detached from the oven door, posing a potential safety hazard. 2. Splintered areas were observed on the handrails of the ramp. 3. The floor of the closet located underneath the stairs in the basement, was observed to be full of bags and other items which were stored directly on the floor. 4. The garage, which was used as a storage area, was noted to be almost completely filled with various items, such as boxes, furniture and adaptive equipment. Many boxes were stored directly on the floor. The residential director (Staff #2) acknowledged the above identified findings and indicated that he would report the concerns to the management for the appropriate action.	I 090	I090 Wires against the exterior wall of the house will be secured by the utility company on November 13, 2012. Please see attachment #2. New cooking range will be installed in the Kitchen by 11/30/12. Please see attachment #6 Splintered areas on the handrails of the ramp were sanded and painted on 11/12/12. The floor of the closet located underneath the stairs in the basement was cleared and arranged all the boxes on the shelf on 10/22/12. The garage, which is used as a storage area, will be cleared and arrange all the items above the ground level by 11/14/12. In future QIDP and the Facility Coordinator will conduct monthly environmental audit of the residential facility and identify issues to prevent reoccurrence. In service training was completed on 11/09/12 See attachment #3(a)	

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I 379	<p>3519.10 EMERGENCIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with individual disabilities (GHPID) failed to ensure an unusual incident that interfered substantially with the resident's health was reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of two residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On October 18, 2012, at 9:30 a.m., the review of an unusual incident report dated September 25, 2012, revealed Resident #2 was taken to the hospital emergency room due to episodes of vomiting. Further review of the incident report revealed no evidence that DOH was notified verbally or in writing.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on October 18, 2012, at 10:45 a.m., revealed all unusual incidents were reported to the agency's incident management coordinator (IMC), who ensured that the appropriate notifications were made. She further</p>	I 379	<p>I 379 ILS will ensure that all DOH 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.</p> <p>ILS hired new IMC on October 1, 2012 and the IMC will ensure to follow the incident reporting policy and procedures as mandated.</p> <p>See attachment #5</p>	

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I 379	Continued From page 4 indicated that she would follow-up with the incident management coordinator to determine when Resident #2's ER visit was reported to DOH. On October 19, 2012, at 4:00 p.m., upon further interview with the QIDP and the review of available records, it was determined that Client #2's ER visit was not reported to DOH as required.	I 379			

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R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check, for six of the eleven staff employed. (Staffs #3 and #4) (LPN #1, #2, #4 and #5)</p> <p>The findings include:</p> <p>Review of the personnel files on October 18, 2012, beginning at 11:49 a.m., revealed the GHPID failed to provide evidence of criminal background checks that disclosed a seven year history of all jurisdictions where six staff worked and/or resided at the time of the survey as evidenced below.</p> <p>a. Staff #3 had a background check conducted where she worked (District of Columbia), but did not have a background check in the jurisdiction in which she resided (Maryland).</p> <p>b. Staff #4 was hired on December 1, 2008. A background check was conducted on February 18, 2009, for the District of Columbia and Chicago, but the report states that the background check was still in progress.</p>	R 125		

Health Regulation & Licensing Administration

TITLE

(X8) DATE

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

STATE FORM

6899

HDD211

If continuation sheet 1 of 2

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2012
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7425 8TH STREET NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 125	Continued From page 1 c. LPN #1 was hired on January 10, 2011. A background check was conducted on January 18, 2011, for the District of Columbia, but the report states that the background check was still in progress. d. LPN #2 was hired on February 9, 2011. A background check was conducted on February 17, 2011, for the District of Columbia and Maryland, but the report states that the background check was still in progress. e. LPN #4 was hired on January 11, 2011. A background check was conducted on October 5, 2010, for the District of Columbia and Maryland, but the report states that the background check was still in progress. f. LPN #5 was hired on February 9, 2011, A background check was conducted on February 17, 2011, for the District of Columbia and Maryland, but the report states that the background check was still in progress. Interview with the house manager (Staff #2) on October 18, 2012, at approximately 12:30 p.m., revealed that she did not have the aforementioned findings and she will consult with human resources.	R 125	<p>R 125</p> <p>Staff#3 Maryland Back ground check was done on 3/17/11. See attachment # 4(a) for staff #3.</p> <p>Staff#4 Background checks for District of Columbia and Chicago was completed on 11/04/12 See attachment # 4(b) for staff #4</p> <p>LPN #1 Background checks for District of Columbia was completed on 10/23/12 See attachment # 4(c) for LPN #1</p> <p>LPN #2 Background checks for District of Columbia and Maryland was completed on 10/23/12. See attachment # 4(d) for LPN #2</p> <p>LPN #3 Background checks for District of Columbia and Maryland was completed on 10/24/12. See attachment # 4(e) for LPN #4</p> <p>LPN #5 Background checks for District of Columbia and Maryland was completed on 2/22/11 See attachment # 4(f) for LPN #5</p> <p>HR Director will ensure to have the all the HR personnel records to be in compliance with the policy.</p>	