PRINTED: 06/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A 37 17		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G212	B. WING			05/10/2013	
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOULTIONS, INC			74	EET ADDRESS, CITY, STATE, ZIP CODE 116 BLAIR ROAD, NW 'ASHINGTON, DC 20012			
(X4) ID PREFIX TAG	FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		THE STREET BY AN OF CORDEC		BE	(X5) COMPLETION DATE
W 000	8, 2013 through Ma of three clients was five males with van	rvey was conducted from May ay 10, 2013. A random sample selected from a population of ying degrees of intellectual arvey was initiated utilizing the	W	000	31 *	sgr	
	observations in the interviews with dire administrative staff	survey were based on home and two day programs, ct support staff, nursing and , as well as a review of client records, including incident		· · · · · · · · · · · · · · · · · · ·			
W 159	(QMRP) will be refe disabilities professi	etardation professional erred to as qualified intellectual onal (QIDP) within this report.) FIED MENTAL RETARDATION	w <sup>.</sup>	159	•		
٠	integrated, coordinate	treatment program must be ated and monitored by a ardation professional.			¥		
	Based on observat review, the qualified professional (QIDP) services to address wheelchair accessil	s not met as evidenced by: iion, interview and record if intellectual disabilities ) #1 failed to coordinate a recommendation for a ble environment, for one of the in the facility. (Client #5)	e k			•	
	revealed Client #5	y 8, 2013 at 8:55 a.m., ambulated with the assistance	*		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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event |D: 9D3211

Facility ID: 09G212

If continuation sheet Page 1 of 7

PREFIX (EACH DEFICIENCY	, INC  EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	7	REET ADDRESS, CITY, STATE, ZIP CODE 416 BLAIR ROAD, NW	05/10/201
PREFIX (EACH DEFICIENCY			WASHINGTON, DC 20012	
	C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
a.m., indicated that survey, an administrategarding the recommendation and the current status of recommendation.  Review of Client #5's assessment dated Alat 12:57 p.m., reveal lower extremity weak deviations, and the commendation of the fallower extraction of the fallower extraction of the fallower extraction of the fallower extraction is require steps at all entrances.  At the time of the surcoordinate services to recommendation that from a wheelchair acceptable.	#1 on May 9, 2013 at 9:22 several weeks prior to the ative discussion was held mendation that Client #5 coessible environment, t present. Additionally, QIDP had not been informed of the plan to address the physical therapy pril 9, 2013, on May 10, 2013 ed the client had upper and the sand multiple galt lient "May benefit from a e living environment."  cility's environment on May avel between the first and incility. Additionally, do ascend and decend the sand exits of the facility.  vey, QIDP #1 failed to address the PT Client #5 "May benefit cessible living environment."  CIAN SERVICES  ide or obtain preventive and	W 159	Wheel chair accessibility living environment for Client #5: the architectural design/plan is attached by not foreseeing and issues waiting for permits with 30 days by July 31st 2013.  See attachment # 1	y

STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  (X BUILDING				
	1	09G212	B. WING	· · . 3		05/	10/2013	
*	ROVIDER OR SUPPLIER	s, INC		74	EET ADDRESS, CITY, STATE, ZIP CODE 116 BLAIR ROAD, NW IASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)			(X5) COMPLETION DATE	
W 322	failed to ensure the antibiotic prescribe	age 2 v and record review, the facility timely provision of an d to treat an infection for one ne sample. (Client #3)	W	322	l was	3	The property of the control of the c	
e(	The finding include	s:	e*		W322	; ; ;		
	usual incident repo 12;30 a.m., reveale the emergency roo elevated temperatu On May 9, 2013 at review of a nursing September 1, 2012 discharged from the with a physician's of	8:37 a.m., the review of an rt dated August 30, 2012 at d that Client #3 was taken to m (ER) for evaluation of an re and frequent odorous urine. approximately 4:55 p.m., progress note dated, revealed Client #3 was a hospital on August 30, 2012 rder for Amoxicillin twice a day r seven consecutive days.			An interim box policy and a protocol has been establis where frequently/common used antibiotics are availab use with a physician's order to allow time for delivery of medication from the pharm.  All the nurses were trained of the policy and process.	hed ly le for so as the acy,		
	#3's physician's orderevealed "Amoxicille (Augmentin 875 mi prescribed orally events of May 9, 2013 at 5:08 medication administration that the client did not augmentin 875 mg. September 4, 2012 prescribed. Based ophysician's order, the medication should it September 8, 2013 the MAR revealed to the last dose of the	tration record (MAR) revealed of receive the first dose of the until the evening of three days after it was on the September 1, 2012 he last dosage of the nave been administered on However, further review of that the client did not receive Augmentin 875 mg until the			the policy and procedure by Director Of Nursing on 5-10- see attachment #2	the   13		
	On May 10, 2013 at	130 n m. Interview with	ado e r		88 av		g 40	

PRINTED: 06/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDERSUPPLIERICLY IDENTIFICATION NUMBER:  09G212	(X2) MUI A. BUILL B. WING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER TIVE LIFE SOULTIONS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012		110/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
W 322	Primary Licensed Practical Nurse (PLPN) #1, revealed there was no record to show that Client #3 received the Augmentin 875 mg. on September 1, 2012, as prescribed.	W 3	322	201 VCCCCS260440 entered	
W 418	At the time of the survey, there was no evidence that Client #3 received the antibiotic timely after it was prescribed to treat his urinary tract infection. 483.470(b)(4)(ii) CLIENT BEDROOMS  The facility must provide each client with a clean, comfortable mattress.	W 4	New mattresses were purcha	- 4	
1	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the springs were not palpable in the bed mattresses provided for two of three clients in the sample. (Clients #1 and #2)		client # 1 and 2  see attachment #3  In future the QIDP and FC will denvironmental audit to ensure a	o an	2
	The finding includes: On May 10, 2013 beginning at 12:30 p.m. the surveyors were accompanied by the residential director to conduct an inspection of the environment. The findings were confirmed by the residential director.		environmental issues are identif and addressed on a quarterly ba and as and when needed	13 4	
1 1	Client #2's bed mattress contained springs that were palpable through the padding and fabric covering of the mattress.				
	Client #1's bed mattress contained springs that vere easily palpable through the padding and vinyl covering of the mattress.				2
li o	nterview with the residential director during the bservations revealed that the aforementioned				

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

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING COMPLETED							
AND I DAM O	, conscorion		A. BOILD	``.							
	id	09G212	B. WING		ter la	05/	10/2013				
NAME OF O	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE						
				7416	BLAIR ROAD, NW						
TAVONNI	IVE LIFE SOULTION	s, INC	1	WAS	HINGTON, DC 20012						
IVALID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	ON	(X5) COMPLETION				
(X4) ID PREFIX	(FACH DEFIGIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	١	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE PRIATE	DATE				
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	ING		DEFICIENCY						
			1								
W 418	Continued From pa	age 4	W4	18							
		d mattresses had not been									
	previously identified		9 8		S						
W 436		CE AND EQUIPMENT	W 4	36							
	650 0 5			. 5	20						
	The facility must fu	rnish, maintain in good repair, ouse and to make informed		١.			•				
		use of dentures, eyeglasses,		1 1		ŀ					
		communications aids, braces,		- }	€	1					
•	and other devices I	dentified by the		1.	W436	1					
40	interdisciplinary tea	m as needed by the client.				. 1					
					Trunk vest zipper was repaire	20					
5 5 ×	12		•		for Client #5 on 6/5/13.						
-	This STANDARD I	s not met as evidenced by:	200 200	. 1							
<u>.</u>	Based on observa	tion, interview and record 🗀 🗄			New wheel chair for Client #3	3 was					
		failed to ensure Client #5's		2 N	received on 6/14/13.						
		intained in good repair, and ta wheelchair recommended									
		vailable, for two of five clients			QIDP and Nurse to check the						
	in the facility.	randoto, for the of his one the			functionality of the adaptive						
				·	equipment on a weekly and	1					
	The findings include	e: , , , ,			monthly basis. # 5 affaction	nent					
1.0	1. The facility failed	d to ensure the trunk vest on	#1 W		See 11-3 called						
	Client #5's wheelch	air was maintained in good	ti ga	1							
190 * 8	repair.					9					
*	On May 0, 2042, 0:	22 a m. Olient #E welled with		1.							
	his unner torse hen	33 a.m., Client #5 walked with torward, as Direct Support									
	Personnel (DSP) #3	3 escorted him to the van,	200		¥						
-		nis gait belt. DSP #1 then		-							
	showed the surveyo	or the client's wheelchair which	- 8	1.	*						
		on the van at all times to	9 		er en						
		observation of the			500 (MS A) 17 (M)						
	community outings.	I it was equipped with a		s .	**						
		brace, however the zipper on	. S.	1	er (55)	- 1					
		broken and could not be			*	. ]					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED								
	,	09G212	B. WING				(*)		05/	10/2013
	ROVIDER OR SUPPLIER		<u> </u>	STREE 7410	BLAIR F	SS, CITY, STAROAD, NW		DE		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID PREF TAG	IX	PI	ROVIDER'S PI H CORRECT REFERENC	LAN OF CO	1 SHOUL	D BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION).	1			DE	FICIENCY)			<u> </u>
W 436	Continued From pa	ge 5	w.	436				3	(3)	
	a.m. indicated that was to help suppor more upright position	#1 on the same day at 8:36 the purpose of the trunk brace t the Client #5's body in a on when he is sitting in the							**	
	wheelchair. Intervi- intellectual disabiliti May 9, 2013, at 9:2 the broken zipper a	ew with the qualified tes professional (QIDP) #1 on 2 a.m., revealed staff reported and a "Prior Authorization				(85) SI	95	***	14 140	
*	obtain a replaceme wheelchair.	ed to the funding agency to nt trunk vest for Client #5's				<b>a</b>	504	(#) (#)	Ę	*)
	"Prior Authorization for a "trunk brace- I replacement for wh review. However, t the replacement tru	t approximately 1:30 p.m., a Form", dated April 21, 2013, proken zipper needs eelchair," was presented for he anticipated delivery date of ink brace zipper was not			~ ·	is e		, a	¥	
	ensure the wheelch	urvey, the facility failed to pair trunk brace recommended 's upper body was maintained				8. sa	* 5	- 122 - 122	2 E	¥
æ.	The facility failed available as recommend appointments facilities.	to ensure a wheelchair was mended for distance travel or Client #3.			*			æ		E
	p.m., Client #3 was forth three times fro dining room toward rapid short steps, s	etween at 5:43 p.m. and 5:50 observed to walk back and om the living room, through the s his bedroom. He took very topping at intervals, as he				e e	36	€ • •	® ₩ ⊕	
	navigated around th	ne furnishing, touching items I by them. He was observed	ŀ					*		3

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

STATEMENT	OF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G212	(X2) MULTIPI A BUILDING B. WING	LL Danomac iven	(X3) DATE SURVEY COMPLETED 05/10/2013	
55 3.40	ROVIDER OR SUPPLIER  IVE LIFE SOULTIONS, INC	. 7	REET 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)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
W 436	Continued From page 6 to flop down on the seat of the couch, and then repeated the aforementioned actions.	W 436			
	On May 8, 2013 at 9:11 p.m., primary licensed practical nurse (PLPN) #1 administered Client #3 Carbid/Levo25/100 milligrams, two tablets. The nurse revealed the client received the medication due to his worsening Parkinson's disease and increased tremors.  On May 10, 2013 at 1:11 p.m., interview with the qualified intellectual developmental professional				
	(QIDP) #1, revealed Client #3 previously had a wheelchair available for his use during community outings (long distances) and for medical appointments, as recommended by the physical therapist (PT). However, the client's wheelchair was a "loaner" and was returned to the rental agency. QIDP#1 indicated that a prior				
* *** *	authorization should have been submitted to the funding agency to obtain Client #3's own wheelchair after the loaner chair was returned, and that she would follow-up on the status of the wheelchair.			•	
*	On May 10, 2013 at 1:15 p.m., review of a PT note dated June 25, 2012 revealed Client #3 "has the potential to fall. He has multiple gait deviations. He can use a wheelchair for extended community outings and medical appointments."				
,	At the time of the survey, there was no evidence that the wheelchair recommended for Client #3's community outings and appointments was available.				

	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HFD03-0206		B. WING			05/1	0/2013
NAME OF P	ROVIDER OR SUPPLIER		STREETAD	DRESS, CITY,	STATE, ZIP CODE			
TAVONNI	TIVE LIFE SOULTIONS	S, INC		MR ROAD, N STON, DC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD COMPANY CONTROL OF CORRECTIVE ACTION SHOULD COMPANY C			) BE	(X5) COMPLETE DATE
1 000	INITIAL COMMENT	·s		1 000				
Transition of the second secon	A licensure survey v 2013 through May 1 three residents was five males with vary disabilities.	0, 2013. A random selected from a pop	sample of ulation of		± 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,			
	The findings of the sobservations in the linterviews with direct administrative staff, resident and administrative reports.  [Qualified mental reformation of the companion of t	home and two day protest support staff, nursing as well as a review of strative records, includered to as qualified in	rograms, ng and of uding Il			20		
1	disabilities professio 3504.1 HOUSEKEE		s tebour!	1090	er be			
	The interior and extermaintained in a safe and sanitary manner accumulations of directions.	, clean, orderly, attra and be free of	ctive,		* N			
1 (	This Statute is not meased on observation home for individuals (GHIID) failed to mai accordance with the residents in the facilitiand #5)	n and interview, the with intellectual disalentain the environmer needs of five of the f	bilities nt in ive					
.   6	The findings include: On May 10, 2013, be surveyors were accordirector to conduct ar	ginning at 12:30 p.m mpanied by the resid				e e e e e e e e e e e e e e e e e e e	de deservations, compared to the second seco	

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Health R	egulation & Licensing Administration	- 001107011	CX3) DA	TE SURVEY				
STATEMEN	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	4	COMPLETED					
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. M. L.	<del>in real</del> . The			
College C		1	B. WING	7/10/2013				
	HFD03-0206		ORESS, CITY, 8	TATE ZIP CO				
NAME OF P	KOVIDEN ON OUT FIELD		IR ROAD, N		2 - 1934			
INNOVATIVE LIFE SOULTIONS, INC WASHING		SHING	TON, DC 20	0012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		DESCRIPTION OF ACHIE		ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE		
1 090	Continued From page 1		l ó30	1 090		1		
	environment. The findings identified were	1	8 %	2	Area rugs were removed			
	confirmed by the residential director.	- 1	a a	a.		-		
		ادن	a) a		from the bathroom floors.			
	<ul> <li>A. Area rugs in the bathrooms lacked non-sk backing, which allowed them to move freely of</li> </ul>	on'	90	h	Light bulbs in the fixture at	1		
	the floor when pressure was applied and			J	the front door were replaced			
0#	presented potential trip hazards.				SALAR CONTRACTOR NO. NO. 10. 10. 12. 13. 13.			
	n I blue had be to the fixture of the front entran	920			by new bulbs on 6/10/13.			
47 1	B. Light bulbs in the fixture at the front entran door were not operable.	.		C.	Railings from the first floor to			
					the basement were fixed by			
	C. The railing located at the top of the stairs.		pe col	*	SALAMI TON THE SALAMI S			
5.	leading from the first floor to the basement, w not tightly secured to the floor. This caused s	light			placing an angler on 6/10/13.			
,	mobility of the railing when it was leaned upon	n for		. 4	Light bulbs with higher			
	support.		£ **	u.	wattage were replaced in all			
jana e	D. The lighting in all three bed rooms was din	n .				i		
	Closer observation of the lamps in the bedroo	oms	A) 		the three bedrooms on			
	revealed each had a three way fixture; however	ver,	6.34		6/10/13.			
	the wattage of the light bulbs remained	. 1	, 8 1 N	1 .	Light bulb in the laundry	2		
1 .	unchanged when the switch was turned.	.		e.				
	E. Lighting in the laundry/utility room located l	ln .	9		room was replaced with high			
*O**	the basement was also very dim. Closer	-	1 v 10		wattage bulb and the			
	observation of the laundry room revealed dust/soil was observed beside and behind the	.	ž		dust/soil was thoroughly			
	appliances and equipment located in the roor	n.	A. 1		cleaned beside and behind			
	25 10 20 20	- 1	56 54		the appliances on 6/10/13.	eri]		
	F. Several holes were observed in the screen		9 & 9	d.				
	the kitchen window, which created a potential the entrance of pests.	1101		f.	The window screen in the			
	The second secon	٠. ا	482 E F		kitchen was replaced with			
	G. The screen was missing from one of the to		. NES	Y.,	new screen on 6/10/13.			
i.	windows in the laundry room located in the	.				-		
	basement.	.		g.	The window screen in the			
	H. There was a nest growing on the outside r	ight	5 a		laundry room was replaced			
	of the home near the fire bell. It appeared to bee hive, creating a potential for bites/injury.	be a			with new screen on 6/10/13.			

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No. They are		a A dualistantian				(8)	- C				
STATEMEN	Regulation & Licensing of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	RICLIA	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
11101011	aer estantación e :					× ×	×				
				o mano	¥	OE)	1010043				
		HFD03-0206	15.1	B. WING		05/	10/2013				
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE							
INNOVAI	TIVE LIFE SOULTIONS	B, INC		NR ROAD, NETON, DC 2	20012		_				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE				
1 090	Continued From page 2			1 090	h. The birds nest near	the fire					
	I. The shield necessary to protect the light bulb underneath the range hood was missing.				bell was removed or	1 6/10/13					
	J. The cement block installed at the bottom of				i. The shield to protec	t the light					
	J. The cement bloc	k installed at the bot froom exit door was	tom of proken off		bulb in the range wi	l be					
•	on the end. Additio	nally, an open space	was	<u>.</u>	installed on 6/14/13						
haya in the	block and the pave	the right side of the c d walkway. These co	nditions	son a	j. The cement block ar	nd the					
4.7	created potential tri	p hazards.			open spaces in the p	aved					
	K. The end of the d	ownspout located on	the right		walkway were repai	red on					
	side (rear) of the fa	cility was partially obs	structed		6/10/13.	100					
. W	with debris.		. 54			<del></del> -					
i s	L. The springs in the	e mattresses on the	peds of		k. Debris was cleared	1 3					
	Residents #1 and #	2 were palpable thro	ugh the		from the end of th						
	outer coverings and - Resident #2's bed	l mattress contained	springs	2 .	downspout on the						
	that were palpable t	hrough the padding	and fabric	1 440 A	side of the facility	on					
	covering of the mat	mattress contained	springs		6/10/13.	ell e					
	that were easily pall vinyl covering of the	pable through the pa	dding and		I. New mattresses v	vere					
	vinyi covering or the	mamoos.			replaced for Clien						
1 401	3520.3 PROFESSIO	ON SERVICES: GEN	ERAL	1 401	and #2 by 6/13/1	3,					
	PROVISIONS	8		es es	L. future the maint	enance					
*		es shall include both			In future the maint manager will do an environ						
* *		uding identification of is and needs, treatme			audit interior and exterior	of the	1				
		es designed to preve		*	building to ensure a	ll the					
8		ner loss of function by			environmental issues	are					
. !	resident.			15 * *	identified and addressed	on a	· ·				
1	This Claterts is set	mot as suidensed him	. · · · · ·		quarterly basis and as and	witen					
į	Resed on interview	met as evidenced by: and record review, th	e group	a #	needed.	i					
	home for persons w	ith intellectual disabil	ities		Į.	1					
	(GHPID) failed to er	sure the timely provi	sion of	- 2	e <sup> E0</sup>	j					
Ì	an antihintic prescri	ned to treat an infecti	on for		sac .	İ	1				

Control of Section 1988 and 1988

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Health F	Regulation & Licensin	a Administration				is "7,50 is	187 188	ACCEPTANT TO A 1-0-000 COLUMN TO THE COLUMN
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI	ER/CLÍA	(X2) MULTIPI	LE CONSTRUCTION		(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NU		A. BUILDING		· · · · · · · · · · · · · · · · · · ·	COMP	PLETEO
						35		
		HFD03-0206		B. WING	98.1	<u> </u>	05/1	0/2013
MAME OF	PROVIDER OR SUPPLIER	711 200-0200	STREET AD	DRESS CITY	STATE, ZIP CODE	<u> </u>		
NAME OF	PROVIDER OR SUPPLIER	# *** B.		IR ROAD, N				
INNOVA	TIVE LIFE SOULTIONS	S, INC		TON, DC 2				
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY	FULL	ID PREFIX	(EACH CORR	'S PLAN OF CORRE	OULD BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMA	MION) .	TAG	CROSS-REFERI	ENCED TO THE API DEFICIENCY)	PROPRIATE	DATE
						DEFICIENT		
1 401	Continued From pa	ge 3	×	ľ 401				
	one of three resider #3).	nts in the sample. (R	esident					
10								
	The finding includes	s:						
ii	On May 9, 2013 at 8	3:37 a.m., the review	ofan					
		t dated August 30, 2						
		d that Resident #3 w						
		om (ER) for evaluati						
8	elevated temperatur			The s		3 .		1
		approximately 4:55 p	.m.,		· .	8		1
		progress note dated			* = 4		9	
	September 1, 2012,			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	*C	<i>a</i> *		
	discharged from the with a physician's or				5		70	
	(every 12 hours) for			- 10 - 10 - 10	)#			
	(0.01) 12 1104(0) 101		,	1 H 18		8		
ĺ	On May 9, 2013 at 5	:03 p.m., review of F	Resident	32 N			1	
	#3's physician's orde		1, 2012	2.47	El jota	9	į	-
	revealed "Amoxicilling				:#: :: ::::::::::::::::::::::::::::::::		1	
	(Augmentin 875 mill	igrams), 1 tab orally	was .			er .	•	Ī
	prescribed orally eve	ery 12 hours for / da	ys. On				2	
	May 9, 2013 at 5:08 medication administ		rovaniad		38	₹ 2		
	that the resident did				# P	· ·		
	the Augmentin 875 r				*		į	i
ļ	September 4, 2012,			*			ĺ	
	prescribed. Based o	n the September 1, 2	2012		1			
1	physician's order, the	e last dosage of the	m e					
	medication should ha							
	September 8, 2013.				#	_		
	the MAR revealed th					無	1	
	receive the last dose until the evening of S					* *	185	
1	and the evening of s	ehreimer 11' 5015'	·	· .	Y <sub>12</sub>		<i>ti</i>	
i i	On May 10, 2013 at	1:30 p.m., interview	with			Carl 18		
	Primary Licensed Pra			* * 3	1.51	107	į	1
	revealed there was n						1	ĺ
	Resident #3 received	the Augmentin 875				20		
	September 1, 2012,	as prescribed.			*		1	į.

Health Regulation & Licensing Administration (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: HFD03-0206 05/10/2013 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 (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1401 1401 Continued From page 4 On May 10, 2013 at 1:30 p.m., review of Resident #3's physician's order dated September 1, 2012 1401 revealed Amoxicillin Clavulanate tablet (Augmentin 875 mg), 1 tab orally was prescribed Client # 3 received his full course orally every 12 hours for 7 days. Interview with of antibiotics upon the availability Primary Licensed Practical Nurse (PLPN) #1, revealed there was no record to show that of the medication. See Resident #3 received the Augmentin 875 mg. on attachment##(policy) September 1, 2012, as prescribed. At the time of the survey, there was no evidence that Resident #3 received the antibiotic timely after it was prescribed to treat his urinary tract infection.

Health Regulation & Licensing Administration

STATE FORM