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	A. BUILDING _____ B. WING _____	05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOULTIONS, INC	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)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from May 8, 2013 through May 10, 2013. A random sample of three clients was selected from a population of five males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the qualified intellectual disabilities professional (QIDP) #1 failed to coordinate services to address a recommendation for a wheelchair accessible environment, for one of the five clients residing in the facility. (Client #5) The finding includes: Observation on May 8, 2013 at 8:55 a.m., revealed Client #5 ambulated with the assistance	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: P. Donald — TITLE: Director of Quality Assurance — (X6) DATE: 6/12/13

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 159	Continued From page 1 of staff and the use of a gait belt. Interview with QIDP #1 on May 9, 2013 at 9:22 a.m., indicated that several weeks prior to the survey, an administrative discussion was held regarding the recommendation that Client #5 have a wheelchair accessible environment, however she was not present. Additionally, QIDP #1 indicated that she had not been informed of the current status of the plan to address the recommendation. Review of Client #5's physical therapy assessment dated April 9, 2013, on May 10, 2013 at 12:57 p.m., revealed the client had upper and lower extremity weakness and multiple gait deviations, and the client "May benefit from a wheelchair accessible living environment." Observation of the facility's environment on May 10, 2013 at 1:00 p.m., revealed it was necessary to use the stairs to travel between the first and second level of the facility. Additionally, ambulation is required to ascend and decend the steps at all entrances and exits of the facility. At the time of the survey, QIDP #1 failed to coordinate services to address the PT recommendation that Client #5 " May benefit from a wheelchair accessible living environment."	W 159	W159 Wheel chair accessibility living environment for Client #5: the architectural design/plan is attached by not foreseeing any issues waiting for permits within 30 days by July 31st 2013. See attachment # 1	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by:	W 322		

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W 322	Continued From page 2 Based on interview and record review, the facility failed to ensure the timely provision of an antibiotic prescribed to treat an infection for one of three clients in the sample. (Client #3) The finding includes: On May 9, 2013 at 8:37 a.m., the review of an usual incident report dated August 30, 2012 at 12:30 a.m., revealed that Client #3 was taken to the emergency room (ER) for evaluation of an elevated temperature and frequent odorous urine. On May 9, 2013 at approximately 4:55 p.m., review of a nursing progress note dated September 1, 2012, revealed Client #3 was discharged from the hospital on August 30, 2012 with a physician's order for Amoxicillin twice a day (every 12 hours) for seven consecutive days. On May 9, 2013 at 5:03 p.m., review of Client #3's physician's order dated September 1, 2012 revealed "Amoxicillin Clavulanate tablet (Augmentin 875 milligrams), 1 tab orally was prescribed orally every 12 hours for 7 days. On May 9, 2013 at 5:08 p.m., review of the medication administration record (MAR) revealed that the client did not receive the first dose of the Augmentin 875 mg. until the evening of September 4, 2012, three days after it was prescribed. Based on the September 1, 2012 physician's order, the last dosage of the medication should have been administered on September 8, 2013. However, further review of the MAR revealed that the client did not receive the last dose of the Augmentin 875 mg until the evening of September 11, 2012. On May 10, 2013 at 1:30 p.m., interview with	W 322	W322 An interim box policy and a protocol has been established where frequently/commonly used antibiotics are available for use with a physician's order so as to allow time for delivery of the medication from the pharmacy. All the nurses were trained on the policy and procedure by the Director Of Nursing on 5-10-13 see attachment #2	

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W 322	Continued From page 3 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. 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.	W 322		
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. 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) 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. - 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 were easily palpable through the padding and vinyl covering of the mattress. Interview with the residential director during the observations revealed that the aforementioned	W 418	W418 New mattresses were purchased and replaced on 6/13/13 for Client # 1 and 2 see attachment #3 In future the QIDP and FC will do an environmental audit to ensure all the environmental issues are identified and addressed on a quarterly basis and as and when needed	

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W 418	Continued From page 4 condition of the bed mattresses had not been previously identified.	W 418		
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 Client #5's wheelchair was maintained in good repair, and failed to ensure that a wheelchair recommended for Client #3 was available, for two of five clients in the facility. The findings include: 1. The facility failed to ensure the trunk vest on Client #5's wheelchair was maintained in good repair. On May 9, 2013, 8:33 a.m., Client #5 walked with his upper torso bent forward, as Direct Support Personnel (DSP) #3 escorted him to the van, while holding onto his gait belt. DSP #1 then showed the surveyor the client's wheelchair which he stated remained on the van at all times to ensure it was available for distance travel and community outings. Observation of the wheelchair revealed it was equipped with a seatbelt and a trunk brace, however the zipper on the trunk brace was broken and could not be	W 436	W436 Trunk vest zipper was repaired for Client #5 on 6/5/13. New wheel chair for Client #3 was received on 6/14/13. QIDP and Nurse to check the functionality of the adaptive equipment on a weekly and monthly basis. See #5 attachment	

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W 436	Continued From page 5 zipped. Interview with DSP #1 on the same day at 8:36 a.m. indicated that the purpose of the trunk brace was to help support the Client #5's body in a more upright position when he is sitting in the wheelchair. Interview with the qualified intellectual disabilities professional (QIDP) #1 on May 9, 2013, at 9:22 a.m., revealed staff reported the broken zipper and a "Prior Authorization Form" was submitted to the funding agency to obtain a replacement trunk vest for Client #5's wheelchair. On May 10, 2013 at approximately 1:30 p.m., a "Prior Authorization Form", dated April 21, 2013, for a "trunk brace- broken zipper needs replacement for wheelchair," was presented for review. However, the anticipated delivery date of the replacement trunk brace zipper was not available. At the time of the survey, the facility failed to ensure the wheelchair trunk brace recommended to support Client #5's upper body was maintained in good repair. 2. The facility failed to ensure a wheelchair was available as recommended for distance travel and appointments for Client #3. On May 8, 2013, between at 5:43 p.m. and 5:50 p.m., Client #3 was observed to walk back and forth three times from the living room, through the dining room towards his bedroom. He took very rapid short steps, stopping at intervals, as he navigated around the furnishing, touching items lightly as he passed by them. He was observed	W 436		

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W 436	Continued From page 6 to flop down on the seat of the couch, and then repeated the aforementioned actions. 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.	W 436		

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I 000	INITIAL COMMENTS A licensure survey was conducted from May 8, 2013 through May 10, 2013. A random sample of three residents was selected from a population of five males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, nursing and administrative staff, 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 group home for individuals with intellectual disabilities (GHIID) failed to maintain the environment in accordance with the needs of five of the five residents in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: On May 10, 2013, beginning at 12:30 p.m. the surveyors were accompanied by the residential director to conduct an inspection of the	I 090		

Health Regulation & Licensing Administration

C. Dimolula — Director of Quality Assurance — 6/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Health Regulation & Licensing Administration

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I 090	Continued From page 1 environment. The findings identified were confirmed by the residential director. A. Area rugs in the bathrooms lacked non-skid backing, which allowed them to move freely on the floor when pressure was applied and presented potential trip hazards. B. Light bulbs in the fixture at the front entrance door were not operable. C. The railing located at the top of the stairs, leading from the first floor to the basement, was not tightly secured to the floor. This caused slight mobility of the railing when it was leaned upon for support. D. The lighting in all three bed rooms was dim. Closer observation of the lamps in the bedrooms revealed each had a three way fixture; however, the wattage of the light bulbs remained unchanged when the switch was turned. E. Lighting in the laundry/utility room located in the basement was also very dim. Closer observation of the laundry room revealed dust/soil was observed beside and behind the appliances and equipment located in the room. F. Several holes were observed in the screen in the kitchen window, which created a potential for the entrance of pests. G. The screen was missing from one of the two windows in the laundry room located in the basement. H. There was a nest growing on the outside right of the home near the fire bell. It appeared to be a bee hive, creating a potential for bites/injury.	I 090	I 090 a. Area rugs were removed from the bathroom floors. b. Light bulbs in the fixture at the front door were replaced by new bulbs on 6/10/13. c. Railings from the first floor to the basement were fixed by placing an angler on 6/10/13. d. Light bulbs with higher wattage were replaced in all the three bedrooms on 6/10/13. e. Light bulb in the laundry room was replaced with high wattage bulb and the dust/soil was thoroughly cleaned beside and behind the appliances on 6/10/13. f. The window screen in the kitchen was replaced with new screen on 6/10/13. g. The window screen in the laundry room was replaced with new screen on 6/10/13.	

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I 090	Continued From page 2 I. The shield necessary to protect the light bulb underneath the range hood was missing. J. The cement block installed at the bottom of the steps of the bedroom exit door was broken off on the end. Additionally, an open space was observed between the right side of the cement block and the paved walkway. These conditions created potential trip hazards. K. The end of the downspout located on the right side (rear) of the facility was partially obstructed with debris. L. The springs in the mattresses on the beds of Residents #1 and #2 were palpable through the outer coverings and padding. - Resident #2's bed mattress contained springs that were palpable through the padding and fabric covering of the mattress. - Resident #1's bed mattress contained springs that were easily palpable through the padding and vinyl covering of the mattress.	I 090	h. The birds nest near the fire bell was removed on 6/10/13 i. The shield to protect the light bulb in the range will be installed on 6/14/13. j. The cement block and the open spaces in the paved walkway were repaired on 6/10/13. k. Debris was cleared from the end of the downspout on the right side of the facility on 6/10/13. l. New mattresses were replaced for Client #1 and #2 by 6/13/13. In future the maintenance manager will do an environmental audit interior and exterior of the building to ensure all the environmental issues are identified and addressed on a quarterly basis and as and when needed.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. 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 ensure the timely provision of an antibiotic prescribed to treat an infection for	I 401		

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I 401	Continued From page 3 one of three residents in the sample. (Resident #3). The finding includes: On May 9, 2013 at 8:37 a.m., the review of an usual incident report dated August 30, 2012 at 12:30 a.m., revealed that Resident #3 was taken to the emergency room (ER) for evaluation of an elevated temperature and frequent odorous urine. On May 9, 2013 at approximately 4:55 p.m., review of a nursing progress note dated September 1, 2012, revealed Resident #3 was discharged from the hospital on August 30, 2012 with a physician's order for Amoxicillin twice a day (every 12 hours) for seven consecutive days. On May 9, 2013 at 5:03 p.m., review of Resident #3's physician's order dated September 1, 2012 revealed "Amoxicillin Clavulanate tablet (Augmentin 875 milligrams), 1 tab orally was prescribed orally every 12 hours for 7 days. On May 9, 2013 at 5:08 p.m., review of the medication administration record (MAR) revealed that the resident did not receive the first dose of the Augmentin 875 mg. until the evening of September 4, 2012, three days after it was prescribed. Based on the September 1, 2012 physician's order, the last dosage of the medication should have been administered on September 8, 2013. However, further review of the MAR revealed that the resident did not receive the last dose of the Augmentin 875 mg. until the evening of September 11, 2012. On May 10, 2013 at 1:30 p.m., interview with Primary Licensed Practical Nurse (PLPN) #1, revealed there was no record to show that Resident #3 received the Augmentin 875 mg. on September 1, 2012, as prescribed.	I 401		

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I 401	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 revealed Amoxicillin Clavulanate tablet (Augmentin 875 mg), 1 tab orally was prescribed orally every 12 hours for 7 days. Interview with Primary Licensed Practical Nurse (PLPN) #1, revealed there was no record to show that Resident #3 received the Augmentin 875 mg. on 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.	I 401	I 401 Client # 3 received his full course of antibiotics upon the availability of the medication. See attachment#~~4(policy)~~	