

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

PRINTED: 08/06/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/25/2012
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)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from May 23, 2012 through May 25, 2012. A sample of three clients was selected from a population of five men 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 at one day program, interviews with direct support staff, administrative staff and one client's medical guardian, 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, staff interview and record review, the qualified intellectual disabilities professional (QIDP) failed to ensure that clients received a comprehensive functional assessment that included their current sensory-motor development and/or mobility orientation needs, for one of the three clients in the sample. (Client #2) The finding includes:	W 159		

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

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.

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W 159	<p>Continued From page 1</p> <p>On May 23, 2012, at 8:30 a.m., Client #2 and his assigned one on one direct support staff (S1) were observed in the nurse's station. S1 was observed steadying the client as he took a seat by holding the client by the pants belt in the center, lower back. At 8:40 a.m., S1 again held the client's belt in the same manner while assisting him to sit down again. Later that day, at 3:09 p.m., S1 was observed walking directly behind Client #2, holding the client's belt in the back, while they climbed the stairs from the basement up to the main level. S1 was again observed providing the same support (holding the client's belt from behind) while climbing the stairs from the basement on May 24, 2012, at 10:57 a.m.</p> <p>On May 24, 2012, at 3:01 p.m., review of Client #2's Individual Support Plan (ISP), dated April 13, 2012, revealed the following: "Staff report that <client's name> is off balance and may need a gait belt. The QDDP <her name> will speak with <physical therapist's name> to assess." The client's Annual Physical Therapy PT Evaluation, which was performed a month earlier (March 12, 2012), included: "He sits quickly without control...He ambulates with a forward head and flexed trunk. There is decreased bilateral heel strike. He ambulated with shuffled gait at times. His gait is ataxic and uncoordinated. He is provided with contact guard assistance at all times... negotiates stairs with a reciprocal pattern with one handrail. His posture is flexed on the stairs." The assessment did not reflect a need for staff to hold the client's belt when taking a seat or while negotiating stairs. An ambulation protocol, dated October 1, 2009, provided instructions regarding contact guard assistance, with no</p>	W 159	<p>Physical Therapist will provide training to staff regarding proper ways to support Client #2 when ambulating.</p> <p>All staff will be trained on ambulation and stair climbing protocol by physical therapist</p> <p>All recommendations from IDT and consultants will be implemented in a timely manner. QDDP, LPN and RN will receive inservice regarding follow up and implementation of all IDT and consultant recommendations.</p> <p>All recommendations from assessments and team meetings will be reviewed to ensure implementation during QA department quarterly record reviews.</p>	<p>5/25/12</p> <p>5/25/12</p> <p>6/29/12</p> <p>6/22/12</p>

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W 159	<p>Continued From page 2</p> <p>mention of holding him by the belt. Continued review of Client #2's record failed to show evidence of contacts with the PT following the interdisciplinary team recommendation (April 13, 2012) prior to the survey.</p> <p>Further review of Client #2's adaptive equipment records on May 24, 2012, at 3:18 p.m., revealed that on May 23, 2012, at 11:23 a.m., the QIDP sent an e-mail to the PT which stated that the client had sustained "a fall last night and we would like to know if staff needs additional fall precaution training." [Note: Client #2's PT records indicated there had been an attempt to introduce a gait belt in the past (date not indicated) which he reportedly refused to use. The PT assessment dated March 12, 2012, however, did not mention gait belts nor did it indicate whether the client had ever received training on the proper use of a gait belt.]</p> <p>On May 25, 2012, at approximately 10:45 a.m., S1 was again observed holding Client #2's belt in the back while they climbed the stairs from the basement up to the main level. Moments later, interview with S1 and another direct support staff (S2) upstairs in the living room revealed that both staff held the opinion that the client would benefit from a gait belt. At approximately 11:30 a.m., interview with the QIDP revealed that staff had begun raising concerns about Client #2's gait "beginning in March" 2012. She further stated that she thought she had contacted the PT after the ISP meeting April 13, 2012. However, after reviewing the client's PT records and the facility's visitor's log, the QIDP acknowledged that no communications with the PT had been documented prior to the e-mail she sent to him on</p>	W 159			

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W 159	Continued From page 3 May 23, 2012.	W 159		
	There was no evidence the facility sought timely reassessment of Client #2's ambulation needs, to include the PT's determination whether a gait belt was indicated.			
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE	W 261		
	The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.		ILS HRC chairperson will ensure that a community representative is present for all HRC meetings as described in ILS HRC policy.	6/29/12
	This STANDARD is not met as evidenced by: Based on observation, interview and review of the Human Rights Committee (HRC) documentation, the facility failed to ensure that persons with no ownership or controlling interest in the facility reviewed and approved clients' restrictive intervention plans, for two of the three clients in the sample. (Clients #1 and #2)		All HRC members will be sent written invitation for the HRC meeting. If a voting member is not able to attend, the meeting will be rescheduled or an alternative member will be obtained.	6/29/12
	The findings include: During observations of the morning medication administration in the facility on May 23, 2012, beginning at 7:56 a.m., Client #1 received Lorazepam, Depakote, Chlorpromaine and Hydroxyzine. Among the medications that Client #2 was observed being administered that morning were Lorazepam, Risperidone, Diphehydramine and Lithium Carbonate. The		ILS HRC chairperson will ensure all voting members are persons with no ownership or controlling interest in ILS.	6/29/12

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W 261	<p>Continued From page 4</p> <p>medication nurse indicated that the aforementioned medications were incorporated in the two clients' behavior support plans (BSPs). [This was later confirmed through review of Clients #1's and #2's BSPs, dated April 13, 2012.]</p> <p>On May 24, 2012, at 11:30 a.m., review of the minutes for meetings held by the HRC on July 29, 2011, November 4, 2011, February 24, 2012 and May 18, 2012 revealed signatures of those who participated in the committee reviews of Clients #1's and #2's BSPs. Review of the signatures revealed no evidence that "community representatives" had participated.</p> <p>On May 25, 2012, at 12:37 p.m., the qualified intellectual disabilities professional acknowledged that there were no community representative signatures on the clients' summary review sheets.</p> <p>The facility's HRC failed to show evidence that persons with no ownership or controlling interest in the facility participated in committee deliberations and voting.</p>	W 261		
W 262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide evidence that restrictive measures had been reviewed and/or</p>	W 262		

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W 263	Continued From page 6 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 #1) The findings include: 1. During observations of the morning medication administration in the facility on May 23, 2012, beginning at 7:56 a.m., Client #1 received Lorazepam, Depakote, Chlorpromaine and Hydroxyzine. The medication nurse indicated that the aforementioned medications were incorporated in the client's behavior support plan (BSP). This was confirmed on May 24, 2012, at 11:05 a.m., through review of Client #1's BSP, dated April 13, 2012. On May 24, 2012, at 11:55 a.m., review of consent forms in Client #1's record revealed that his court-appointed medical guardian had signed consents for his medications once, on April 13, 2012. A short time earlier, at 11:10 a.m., review of the client's court documents revealed that his guardian had been appointed on November 17, 2011. There was no documented evidence that the client's guardian had been asked to provide	W 263	QDDP will ensure all newly appointed guardians are contacted to inform of all outstanding items (i.e. medical consents) to confirm all items are addressed in a timely manner. ILS will ensure all consents are signed and current in the record. All consents will be reviewed for compliance at the ISP and second quarterly meeting. ILS will ensure the HRC reviews and discuss all individuals who require written consents for any medication, sedation or any other restrictive control. HRC compliance will be monitored quarterly through QA audits.	6/29/12	6/29/12

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W 263	<p>Continued From page 7</p> <p>written consent for his medication regimen from the time she was appointed (November 17, 2011) until April 13, 2012.</p> <p>2. Review of Client #1's medical chart on May 24, 2012, at 12:02 p.m., revealed a physician's order dated February 17, 2012. The order was for the client to receive Ativan 2mg one hour prior to an audiology appointment. Concurrent review of Client #1's medication administration record confirmed that the client received the Ativan sedation on March 27, 2012. Client #1's BSP, dated April 13, 2012, reflected the client's refusal to cooperate on some medical appointments. Desensitization training in the past reportedly had not been effective.</p> <p>On May 24, 2012, at 11:55 a.m., review of consent forms in Client #1's record revealed no evidence that his court-appointed medical guardian had signed a written consent form for the use of Ativan for sedation prior to his audiology appointment on March 27, 2012. The first documented consent form signed by the guardian was dated April 13, 2012.</p> <p>On May 24, 2012, at 11:30 a.m., review of the minutes for meetings held by the facility's HRC on July 29, 2011, November 4, 2011, February 24, 2012 and May 18, 2012 revealed no evidence that the HRC had discussed whether Client #1's medical guardian provided written consent for his medications.</p> <p>The qualified intellectual disabilities professional (QIDP) was present at the time of the May 24, 2012, review of HRC documentation and Client #1's medical consents. At 12:57 p.m., the QIDP</p>	W 263		

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W 263	<p>Continued From page 8</p> <p>stated that she had not asked the medical guardian for written consent prior to April 13, 2012 because previously, on May 6, 2011, the client's mother had signed a consent and she considered that to have been "current." [Note: A QIDP quarterly meeting summary, dated October 10, 2011, indicated that the client's mother had passed on September 23, 2011.]</p> <p>Telephone interview with Client #1's court-appointed medical guardian on May 24, 2012, at 4:45 p.m., confirmed that she was not asked to provide written consent prior to the client's annual Individual Support Plan meeting, held April 13, 2012.</p> <p>The facility's HRC failed to ensure that written consent had been obtained from Client #1's court-appointed medical guardian prior to the implementation of restrictive programs.</p> <p>This is a repeat deficiency. See Federal Deficiency Report dated April 29, 2011.</p>	W 263		
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all drugs were administered without error, for one of the five clients residing in the facility. (Client #1)</p> <p>The finding includes:</p>	W 369		

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W 369	Continued From page 9 The morning medication administration was observed on May 23, 2012, beginning at 7:56 a.m. Client #1 was the last of five clients to receive medications and treatments that morning from 8:50 a.m. - 9:00 a.m. On May 23, 2012, at 3:22 p.m., review of Client #1's physician's order sheets for May 2012 revealed that he was prescribed the following: "Patanol 0.1% eye drops. Instill one drop twice daily into both eyes at 8am and 6pm." Concurrent review of the client's medication administration record revealed that the space for documenting administration of the eye drops had been left blank that morning. Client #1 was not observed receiving eye drops during the morning medication administration that day. Nurses' initials documented administrations up through the evening of May 22, 2012. On May 23, 2012, at 4:15 p.m., the facility's Licensed Practical Nurse (LPN) coordinator looked through the medication closet and was unable to locate Patanol eye drops for Client #1. She surmised that the supply ran out with the evening administration on the night before. She further indicated that she would follow-up with the pharmacy. The facility failed to establish and implement a system to ensure that Client #1 received all prescribed medications without error. This is a repeat deficiency. See Federal Deficiency Report dated April 29, 2011.	W 369	RN's will create a protocol for when medication are low or empty and how/who to report this information. ILS will ensure all prescribed medications are given without error and LPN's will be inserviced on medication administration.	6/29/12 6/29/12	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair,	W 436			

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W 436	<p>Continued From page 10</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure necessary adaptive equipment was acquired timely and maintained in good repair, for one of the two sampled clients whose interdisciplinary teams had recommended adaptive equipment. (Client #2)</p> <p>The findings include:</p> <p>1. On May 23, 2012, at 7:20 a.m., Client #2 was observed wearing a white, plastic helmet while seated in the living room. The chin strap on the helmet was unsecured and dangling from the left side of the helmet. Continued observation revealed a large tear on the right side of the helmet, where the chin strap would normally be secured. The facility coordinator (FC), who was present at that moment, confirmed that the chin strap could not be secured properly due to the tear. Continued interview with the FC revealed that Client #2 had sustained a head injury due to a fall in his bedroom 7 hours earlier.</p> <p>Client #2's habilitation records were reviewed on May 24, 2012, beginning at 3:01 p.m. His Individual Support Plan (ISP), dated April 13,</p>	W 436	<p>All adaptive equipment will be secured in a timely manner.</p> <p>QDDP will complete a weekly note on the status of any outstanding adaptive equipment. If adaptive equipment is not in good repair it will be reported to the clinician who recommended the adaptive equipment to determine if any other precautions should be in place as the adaptive equipment is being acquired or the securement of a loaner item.</p> <p>DSP will complete an adaptive equipment checklist to ensure all equipment is in good repair. All adaptive equipment found not to be in good repair, will be reported to the QDDP or LPN.</p> <p>QDDP will inform Clinical Services Director (CSD) of any delays regarding securing adaptive equipment 60 days after the need was identified.</p> <p>All recommendations from IDT and consultants will be implemented in a timely manner. QDDP, LPN and RN will receive inservice regarding follow up and implementation of all IDT and consultant recommendations.</p>	<p>6/22/12</p> <p>6/29/12</p> <p>6/22/12</p> <p>6/29/12</p> <p>6/22/12</p>

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W 436	<p>Continued From page 12</p> <p>on March 23, 2012. Further review of the client's records failed to show evidence that he had received a wheelchair.</p> <p>The QIDP was asked about Client #2's wheelchair on May 24, 2012, at approximately 4:15 p.m. The client initially had a "loaner" chair available for use during community outings (long distances) and for medical appointments. According to the QIDP, the loaner chair "worked fine." She stated that at some point after April 2011 (date not specified), the facility had to return the loaner chair to the vendor. The QIDP confirmed that the PT approved Client #2 for a wheelchair in June 2011, he was assessed in March 2012, and that to date the client had not received a wheelchair. According to the QIDP, the home sent authorization forms twice to the PCP for his signature but she did not know whether they had been signed. When asked immediately prior to the Exit conference on May 25, 2012, the QIDP stated that the PCP had signed an authorization form that morning and it would be forwarded to the wheelchair vendor.</p>	W 436		

Health Regulation & Licensing Administration

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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) COMPLETE DATE
1 000	INITIAL COMMENTS A licensure survey was conducted from May 23, 2012 through May 25, 2012. A sample of three residents was selected from a population of five men with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at one day program, interviews with direct support staff, administrative staff and one resident's medical guardian, 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.]	1 000		
1 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with Intellectual disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for five of the five residents of the GHPID. (Residents #1, #2, #3, #4 and #5) The finding includes: On May 25, 2012, beginning at 1:05 p.m., the window screen located in Resident #2's bedroom was detached from the window frame. Further	1 091		

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

STATE FORM

0099

KL3411

TITLE

EXCEPTUS DRETAN

(X6) DATE

6/15/12

If continuation sheet 1 of 13

Health Regulation & Licensing 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 05/25/2012
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I 091	Continued From page 1 observations revealed there were three (3) window screens missing from windows located elsewhere around the GHPID. The facility coordinator, who was present at the time, verified the aforementioned maintenance needs. She indicated that the maintenance personnel was in the process of replacing the missing window screens.	I 091	All window screens will be secured and replaced.	6/30/12
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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, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated services (i.e. obtain an updated physical therapy assessment), for one of the three residents in the sample. (Resident #2) The finding includes: On May 23, 2012, at 8:30 a.m., Resident #2 and his assigned one on one direct support staff (S1) were observed in the nurse's station. S1 was observed steadying the resident as he took a seat by holding the resident by the pants belt in the center, lower back. At 8:40 a.m., S1 again held the resident's belt in the same manner while assisting him to sit down again. Later that day, at 3:09 p.m., S1 was observed walking directly behind Resident #2, holding the resident's belt in the back, while they climbed the stairs from the basement up to the main level. S1 was again	I 180	See W159	
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Health Regulation & Licensing 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 05/25/2012	
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I 180	<p>Continued From page 2</p> <p>observed providing the same support (holding the resident's belt from behind) while climbing the stairs from the basement on May 24, 2012, at 10:57 a.m.</p> <p>On May 24, 2012, at 3:01 p.m., review of Resident #2's Individual Support Plan (ISP), dated April 13, 2012, revealed the following: "Staff report that <resident's name> is off balance and may need a gait belt. The QDDP <her name> will speak with <physical therapist's name> to assess." The resident's Annual Physical Therapy PT Evaluation, which was performed a month earlier (March 12, 2012), included: "He sits quickly without control...He ambulates with a forward head and flexed trunk. There is decreased bilateral heel strike. He ambulated with shuffled gait at times. His gait is ataxic and uncoordinated. He is provided with contact guard assistance at all times... negotiates stairs with a reciprocal pattern with one handrail. His posture is flexed on the stairs." The assessment did not reflect a need for staff to hold the resident's belt when taking a seat or while negotiating stairs. An ambulation protocol, dated October 1, 2009, provided instructions regarding contact guard assistance, with no mention of holding him by the belt. Continued review of Resident #2's record failed to show evidence of contacts with the PT following the interdisciplinary team recommendation (April 13, 2012) prior to the survey.</p> <p>Further review of Resident #2's adaptive equipment records on May 24, 2012, at 3:18 p.m., revealed that on May 23, 2012, at 11:23 a.m., the QIDP sent an email to the PT which stated that the resident had sustained "a fall last night and we would like to know if staff needs additional fall precaution training." [Note:</p>	I 180		

Health Regulation & Licensing 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 05/25/2012
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I 180	Continued From page 3 Resident #2's PT records indicated there had been an attempt to introduce a gait belt in the past (date not indicated) which he reportedly refused to use. The PT assessment dated March 12, 2012, however, did not mention gait belts nor did it indicate whether the resident had ever received training on the proper use of a gait belt.] On May 25, 2012, at approximately 10:45 a.m., S1 was again observed holding Resident #2's belt in the back while they climbed the stairs from the basement up to the main level. Moments later, interview with S1 and another direct support staff (S2) upstairs in the living room revealed that both staff held the opinion that the resident would benefit from a gait belt. At approximately 11:30 a.m., interview with the QIDP revealed that staff had begun raising concerns about Resident #2's gait "beginning in March" 2012. She further stated that she thought she had contacted the PT after the ISP meeting April 13, 2012. However, after reviewing the resident's PT records and the facility's visitor's log, the QIDP acknowledged that no communications with the PT had been documented prior to the email she sent to him on May 23, 2012. There was no evidence the facility sought timely reassessment of Resident #2's ambulation needs, to include the PT's determination whether a gait belt was indicated.	I 180		
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.	I 206		

Health Regulation & Licensing 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 05/25/2012
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I 206	Continued From page 4 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 that all employees had a current health certificate/inventory, for 1 out of 16 staff. (Staff #4) The finding includes: On May 25, 2012, beginning at 11:11 a.m., review of the personnel records revealed that Staff #5 had received a PPD test within the past year (results were "negative"). Further review of his personnel record, however, revealed no evidence of a complete physician's health inventory/ certificate. On May 25, 2012, at approximately 1:50 p.m., the qualified intellectual disabilities professional acknowledged that there was no evidence of a comprehensive health inventory performed by a physician for the aforementioned personnel. She stated she would seek additional information from their corporate office. No additional information was presented before the survey ended later that day at 5:30 p.m. This is a repeat deficiency. See Licensure Deficiency Report dated April 29, 2011.	I 206	ILS will ensure all personnel records are complete. All personnel will have a completed physician health inventory certificate and PPD. All personnel records will be reviewed on a quarterly basis by the HR department to ensure compliance.	6/22/12	6/22/12
I 223	3510.4 STAFF TRAINING	I 223	Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.		

Health Regulation & Licensing 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 05/25/2012
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I 223	<p>Continued From page 5</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the training program agenda was maintained in the group home for persons with intellectual disabilities (GHPID) and available for review by regulatory agencies for five of the five residents of the GHPID. (Residents #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>1. On May 25, 2012, at 11:40 a.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that the physical therapist (PT) had provided in-service training "recently." According to the QIDP, the PT demonstrated how to assist Resident #2 while ambulating and discussed the resident's other PT-related issues/supports. However, review of the GHPID's staff in-service training records at 11:15 a.m. had shown no documentation (i.e. agendas and signature sheets) available for review regarding any PT training provided within the previous year. At 11:45 a.m., the QIDP reviewed the same in-service training records and acknowledged that the most recent PT training had been documented on March 15, 2011.</p> <p>On May 25, 2012, at 11:52 a.m., review of the GHPID's visitor's log revealed that the PT had signed-in on March 13, 2012. The QIDP indicated that this corresponded with the PT's assessments of residents, and the PT had provided staff training on the same evening.</p> <p>2. Continued review of the facility's staff in-service training records on May 25, 2012, at 1:07 p.m., revealed a staff signature sheet dated March 15, 2012. The signature sheet indicated that the QIDP had provided training on "Client Safety,"</p>	I 223	<p>All QDDP's and consultants will be inserviced on program training. This will include requirement of an agenda, sign in sheet and training materials for all trainings. 6/29/12</p> <p>A copy of all inservices will be sent to the Training compliance manager. The Training compliance manager will ensure all training have an agenda, sign in sheet and training materials. 6/22/12</p>

Health Regulation & Licensing 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 05/25/2012	
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I 223	Continued From page 6 however, there was no corresponding agenda indicated or attached. The QIDP was asked immediately if there was an agenda available for review. She retrieved a calendar for March 2012 on which general training topics were indicated throughout the month. When queried further regarding what had been discussed with staff at the March 15, 2012 "Client Safety" training, the QIDP indicated that she could not recall. The GHPID failed to consistently make available for review signature sheets and/or agendas of all in-service training provided for its employees.	I 223		
I 500	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 federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for one of the three residents of the GHPID. (Residents #3) The findings include: 1. [483.470(g)(2)] The GHPID failed to furnish and maintain Resident #1's recommended adaptive equipment, as follows:	I 500	See W436 See W262 See W263	

Health Regulation & Licensing 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 05/25/2012
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I 500	Continued From page 7 a. On May 23, 2012, at 7:20 a.m., Resident #2 was observed wearing a white, plastic helmet while seated in the living room. The chin strap on the helmet was unsecured and dangling from the left side of the helmet. Continued observation revealed a large tear on the right side of the helmet, where the chin strap would normally be secured. The facility coordinator (FC), who was present at that moment, confirmed that the chin strap could not be secured properly due to the tear. Continued interview with the FC revealed that Resident #2 had sustained a head injury due to a fall in his bedroom 7 hours earlier. Resident #2's habilitation records were reviewed on May 24, 2012, beginning at 3:01 p.m. His Individual Support Plan (ISP), dated April 13, 2012, indicated he had a history of falls and wore a helmet for safety. At 3:30 p.m., review of the resident's Annual Physical Therapy (PT) Evaluation, dated March 12, 2012, revealed that the white helmet observed with the broken chin strap was already damaged at the time of the assessment. The PT recommended "purchase a new full coverage helmet. Wear the helmet when out of bed. Continue with one on one assistance..." Resident #2's adaptive equipment records indicated that the qualified intellectual disabilities professional (QIDP) had requested the purchase of 2 new helmets previously, on December 27, 2011, and that a 719A authorization form was submitted on January 3, 2012. On May 25, 2012, at 11:22 a.m., interview with the QIDP revealed that the chin strap on the white helmet was broken when she requested new ones on December 27, 2011. She acknowledged there had been delays in securing a new helmet,	I 500			

Health Regulation & Licensing 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 05/25/2012
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I 500	<p>Continued From page 8</p> <p>further indicating that the delay was "partly due to" a delay in securing the primary care physician's (PCP's) signature on the authorization forms. She confirmed that the new, blue helmet was received on May 23, 2012, almost 5 months after the need had been identified.</p> <p>b. While reviewing Resident #2's adaptive equipment records on May 24, 2012, at approximately 3:10 p.m., it was observed that on June 7, 2011, the QIDP documented "PT approved wheelchair." A PT note dated June 8, 2011, reflected the resident was "appropriate to use a wheelchair for extending outings and medical appointments." Continued review of the resident's adaptive equipment records revealed that 8 months passed before he was assessed for a wheelchair, on March 23, 2012. Further review of the resident's records failed to show evidence that he had received a wheelchair.</p> <p>The QIDP was asked about Resident #2's wheelchair on May 24, 2012, at approximately 4:15 p.m. The resident initially had a "loaner" chair available for use during community outings (long distances) and for medical appointments. According to the QIDP, the loaner chair "worked fine." She stated that at some point after April 2011 (date not specified), the facility had to return the loaner chair to the vendor. The QIDP confirmed that the PT approved Resident #2 for a wheelchair in June 2011, he was assessed in March 2012, and that to date the resident had not received a wheelchair. According to the QIDP, the home sent authorization forms twice to the PCP for his signature but she did not know whether they had been signed. When asked immediately prior to the Exit conference on May 25, 2012, the QIDP stated that the PCP had signed an authorization form that morning and it</p>	I 500	

Health Regulation & Licensing 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 05/25/2012
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1500	Continued From page 9 would be forwarded to the wheelchair vendor. 2. [483.440(f)(3)(i)] The GHPID failed to consistently seek its Human Rights Committee's (HRC's) review and approval for programs that incorporate restrictive techniques (i.e. psychotropic medications), as follows: Review of Resident #1's medical chart on May 24, 2012, at 12:02 p.m., revealed a physician's order dated February 17, 2012. The order was for the resident to receive Ativan 2mg one hour prior to an audiology appointment. Concurrent review of Resident #1's medication administration record confirmed that the resident received the Ativan sedation on March 27, 2012. On May 24, 2012, at 11:30 a.m., review of the minutes for meetings held by the facility's HRC on July 29, 2011, November 4, 2011, February 24, 2012 and May 18, 2012 revealed no evidence that the HRC had reviewed and approved the use of sedation for Resident #1's audiology appointment. Interview with the qualified intellectual disabilities professional (QIDP) on May 24, 2012, at approximately 12:30 p.m., revealed that Resident #1 received the sedation to address his non-compliance during the audiology appointment. She indicated that the sedation for medical appointments was incorporated in the resident's behavior support plan (BSP). This was confirmed on May 24, 2012, at 11:05 a.m., through review of Resident #1's BSP, dated April 13, 2012. Moments later, the QIDP acknowledged that review of the Ativan had not been documented on the HRC minutes. The facility failed to provide evidence that its HRC	1500			

Health Regulation & Licensing 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 05/25/2012
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1500	Continued From page 10 reviewed, monitored and/or approved the use of sedation to ensure Resident #1's compliance during a scheduled medical appointment. 3. [483.440(f)(3)(i)] The GHPID failed to ensure that restrictive programs were used only with written consent from residents' court-appointed medical guardians, as follows: a. During observations of the morning medication administration in the facility on May 23, 2012, beginning at 7:56 a.m., Resident #1 received Lorazepam, Depakote, Chlorpromaine and Hydroxyzine. The medication nurse indicated that the aforementioned medications were incorporated in the resident's behavior support plan (BSP). This was confirmed on May 24, 2012, at 11:05 a.m., through review of Resident #1's BSP, dated April 13, 2012. On May 24, 2012, at 11:55 a.m., review of consent forms in Resident #1's record revealed that his court-appointed medical guardian had signed consents for his medications once, on April 13, 2012. A short time earlier, at 11:10 a.m., review of the resident's court documents revealed that his guardian had been appointed on November 17, 2011. There was no documented evidence that the resident's guardian had been asked to provide written consent for his medication regimen from the time she was appointed (November 17, 2011) until April 13, 2012. b. Review of Resident #1's medical chart on May 24, 2012, at 12:02 p.m., revealed a physician's order dated February 17, 2012. The order was for the resident to receive Ativan 2mg one hour prior to an audiology appointment. Concurrent review of Resident #1's medication administration record	1500		
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Health Regulation & Licensing 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 05/25/2012	
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I 500	<p>Continued From page 11</p> <p>confirmed that the resident received the Ativan sedation on March 27, 2012.</p> <p>On May 24, 2012, at 11:55 a.m., review of consent forms in Resident #1's record revealed no evidence that his court-appointed medical guardian had signed a written consent form for the use of Ativan for sedation prior to his audiology appointment on March 27, 2012. The first documented consent form signed by the guardian was dated April 13, 2012.</p> <p>On May 24, 2012, at 11:30 a.m., review of the minutes for meetings held by the facility's HRC on July 29, 2011, November 4, 2011, February 24, 2012 and May 18, 2012 revealed no evidence that the HRC had discussed whether Resident #1's medical guardian provided written consent for his medications.</p> <p>The qualified intellectual disabilities professional (QIDP) was present at the time of the May 24, 2012, review of HRC documentation and Resident #1's medical consents. At 12:57 p.m., the QIDP stated that she had not asked the medical guardian for written consent prior to April 13, 2012 because previously, on May 6, 2011, the resident's mother had signed a consent form and she considered that to have been "current." [Note: A QIDP quarterly meeting summary, dated October 10, 2011, indicated that the resident's mother had passed on September 23, 2011.]</p> <p>Telephone interview with Resident #1's court-appointed medical guardian on May 24, 2012, at 4:45 p.m., confirmed that she was not asked to provide written consent prior to the resident's annual Individual Support Plan meeting, held April 13, 2012.</p>	I 500		

Health Regulation & Licensing 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 05/25/2012	
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I 500	Continued From page 12 The facility's HRC failed to ensure that written consent had been obtained from Resident #1's court-appointed medical guardian prior to the implementation of restrictive programs. This is a repeat deficiency. See Licensure Deficiency Report dated April 29, 2011.	I 500		