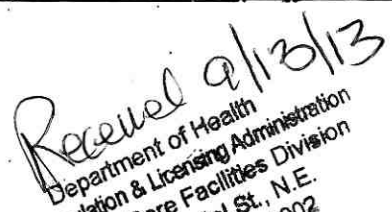


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 114 DIVISION AVENUE, NE WASHINGTON, DC 20019		
(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 August 20, 2013 through August 22, 2013. A sample of three clients was selected from a population of two males and one female with varying degrees of Intellectual disabilities. This survey was initiated utilizing the full survey process. The findings of the survey were based on observations in the home and one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.	W 000	 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP), including Client #1's compact disk (CD)-purchase program, included a data collection system directly related to the outcome of the objective, for one of three clients in the sample. (Client #1) The finding includes: Recent performance data that had been collected for Client #1's training programs was reviewed on	W 237			

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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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 114 DIVISION AVENUE, NE WASHINGTON, DC 20019		
(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 237	<p>Continued From page 1</p> <p>August 22, 2013, beginning at approximately 12:30 p.m. One of the client's training objectives was as follows: "Given verbal and physical assistance, <client's name> will make a selection to purchase a CD of his choice once a week at 100% accuracy." The program was to be implemented every Sunday. The data collection sheet reflected the following methodology: The client (1) "will be given a choice of two stores; (2) will walk through the aisles and pick a CD of his choice; (3) will hand the cashier his money to purchase item; (4) will receive the change and item; and (5) staff will document appropriately."</p> <p>Continued review of the data sheet revealed that the task analysis used for documenting Client #1's performance did not correspond with the methodology that was outlined in the program (the criteria did not match). The form indicated data was to be collected as follows:</p> <p>[1] Select activity; [2] Give money; and [3] Receive money.</p> <p>Line 1 did not specify what choice/activity should be documented. When asked if the line marked "Select activity" was meant for documenting Client #1's choice of stores or his choice of CD, both the qualified intellectual disabilities professional (QIDP) and the facility coordinator (FC) indicated they could not answer with certainty. They further stated that they had not directly observed staff implement the CD-purchase program nor had they received training from the former QIDP consultant regarding that specific program.</p>	W 237			

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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0203	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 114 DIVISION AVENUE, NE WASHINGTON, DC 20019			
(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	
1000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 20, 2013 through August 22, 2013. A sample of three residents was selected from a population of two males and one female with varying degrees of Intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. The survey findings revealed that the facility was in compliance with Chapter 35 regulations.</p>	1000			

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

TITLE

(X6) DATE