

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

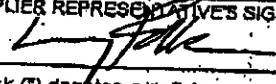
PRINTED: 12/31/2008  
FORM APPROVED  
OMB NO. 0938-0391

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  12/05/2008
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS  A recertification survey was conducted from December 3, 2008 through December 5, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a resident population of four men with various disabilities.  On December 4, 2008, at 3:25 PM, facility management was informed that the survey was being extended in the Condition of Participation in Health Care Services after it was determined that even though Client #1 repeatedly bit his peers (broken skin), there was no established protocol for addressing human bites. While Client #2 had been sent to an emergency room in April 2008 and received a tetanus booster and prophylactic antibiotics, a similar bite to Client #4 was treated with normal saline solution and triple antibiotic ointment (topical), and without evaluation at an ER.	W 000		
W 104	483.410(a)(1) GOVERNING BODY  The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's governing body provided general operating direction, except in the following areas:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Clinical Manager	(X8) DATE 2/2/09
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 104	<p>Continued From page 1</p> <p>The findings include:</p> <p>1. Cross-refer to W262. The governing body failed to ensure its specially constituted committee reviewed and approved increases in medications prescribed to manage behaviors.</p> <p>2. Cross-refer to W149. The governing body failed to establish a protocol to ensure timely and appropriate response to human bites. A December 4, 2008 review of incident reports and client records revealed a continued pattern, past and present, of Client #1 biting his peers. Some clients were sent to an emergency room and received prophylactic antibiotic treatment, while others did not. There was no policy or protocol available for review in the facility. On December 5, 2008, the PCP brought a written statement to the facility. The statement, dated December 4, 2008, did not identify the anticipated/ appropriate response time re: nurse assessment of the bite wound and PCP notification. Further discussions with the LPN and newly-hired RN failed to clarify why one client would be sent to an ER while another would not, when there was evidence of skin break. During the December 8, 2008 Exit teleconference, the facility's Clinical Director stated "we take them to the ER, period. That is our policy." This policy, however, had not been conveyed during the survey. There was no evidence that the facility had established a policy on human bites prior to this survey.</p>	W 104	<p>W 104 ILS will insure review and approval of client medication changes (psychotropic medications) through the Human Rights Committee that meets on the 3<sup>rd</sup> Wednesday of every month.</p> <p>ILS has implemented a Human Bite Policy and Protocol as of 12/12/08, to address any type of human bite as it may occur.</p> <p>The Human Bite Protocol addresses the issue of immediate response to all incident of human bite. Incidents of human bite will be treated at the emergency room. (In case of skin break) The Nurses and PCP will be notified immediately. Implementation (including in service training) provided by the nursing staff on 12/16/08.</p>	<p>1/21/09</p> <p>12/12/08</p> <p>12/16/08</p>
W 111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p>	W 111		

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W 111	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to maintain a record keeping system that contained all pertinent client information in the active client files, for one of the four clients residing in the facility. (Client #4)</p> <p>The findings include:</p> <p>On December 3, 2008, at approximately 5:15 PM, review of Client #4's Medication Administration Records (MARs) revealed that he received treatment for a human bite in July 2008. According to a July 13, 2008 Nurse Progress Note, "Staff reported that individual was bitten by another individual; bite size middle of right forearm. Size 1/2 by 1.2 inches open wound with red tissue effacing. Wound cleansed...triple antibiotic ointment... bandage per MD's order... LPN Nurse and RN Nurse Supervisor made aware." Similar bites received by Clients #3 and #2, on January 20, 2008 and April 24, 2008, respectively, had led to referrals to an emergency room where they received tetanus booster shots.</p> <p>On December 4, 2008, at 1:40 PM, review of Client #4's immunology history/record sheet in his medical chart revealed that the most recent tetanus-diphtheria shot he had received was given on July 23, 1998. It further indicated that he was due for another booster shot in July 2008. Continued review of Client #4's record revealed no evidence, however, that he had received the 10-year tetanus booster shot.</p> <p>On December 4, 2008, at approximately 3:25 PM, interview with an LPN revealed that someone</p>	W 111	<p>W 111 The agency will insure that incidents of human bite will be addressed as outlined in the Protocol. The agency will insure all clients' immunization records are up to date. (Tetanus shot) Client #4 immunization record has been updated. Tetanus shot was given on 12/18/06, good for ten years.</p> <p>W 111 Immunization records will be maintained/reviewed by nursing staff monthly and will be reviewed by the Primary Care Physician annually.</p>	12/18/08
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W 111	Continued From page 3 within the agency had informed her that Client #4 had in fact received a tetanus booster. She acknowledged, however, that the alleged tetanus booster was not reflected in the client's medical chart. The following afternoon (December 5, 2008), the LPN presented a document that she had received just minutes earlier via fax transmittal from a hospital clinic, verifying that Client #4 had received a diphtheria-tetanus booster on December 18, 2006. The LPN acknowledged that the facility had not maintained current immunology records for Client #4.	W 111	W 111 Immunization records will be maintained/reviewed by nursing staff monthly and will be reviewed by the Primary Care Physician annually.	12/18/08	
W 124	<b>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</b>  The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish a system to ensure that each client, or his/her authorized surrogate healthcare decision-maker, was informed of the client's medical condition, benefits and risks of medications and of the right to refuse treatment, for two of the two clients in the sample. (Clients #1 and #2)  The findings include:  1. On December 3, 2008, at approximately 9:30 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that	W 124	W 124  ILS will insure review and approval of client medication changes (psychotropic medications) through the Human Rights Committee that meets on the 3 <sup>rd</sup> Wednesday of every month following the medication review clinic with the Psychiatrist. Consent forms will be generated at each change of incident and the QMRP or Clinical Manager will contact family members, attorneys or guardians for consent the same day. In addition, the Human and Legal Rights Committee will meet the 3 <sup>rd</sup> Wednesday of each month following the medication review clinic to review BSP and Psychotropic medications, or any other human rights issue as needed.	12/18/08	

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W 124	<p>Continued From page 4</p> <p>Client #2's sister was his designated surrogate healthcare decision-maker. On December 4, 2008, beginning at approximately 9:30 AM, review of Client #2's Individual Support Plan (ISP), dated April 11, 2008, revealed that the client functioned in the severe range of mental retardation in cognitive and adaptive skills. The ISP confirmed that his sister was the designated surrogate healthcare decision-maker due to his impaired ability to process information effectively.</p> <p>His December 2008 physician's orders (POs) indicated that his medication regimen included Abilify 30 mg every morning, Lexapro 20 mg every morning, Lorazepam 1 mg twice daily and Zyprexa 10 mg every morning, among other medications, and he received one-on-one staff support as part of his behavior management plan. Further record review revealed that Client #2 was fitted for, and received dentures in September 2008. His psychotropic medication regimen was changed in October 2008, following a new psychiatric evaluation (performed by an outside source, as a second opinion). The daily dose of Lexapro was doubled (from 10 mg to 20 mg) a new medication, Abilify, was added, and the doses of two of his prior medications (Lorazepam and Zyprexa) were reduced. In addition, his cardiology records reflected an October 28, 2008 change in his medication regimen after a cardiologist determined that his hypertension was not being controlled effectively.</p> <p>a. Further review of the ISP revealed no evidence that the sister had been involved in the planning and/or review process (i.e. she had not attended meetings, there were no documented telephone calls or written communications, etc.).</p>	W 124	see W 124 page 4 of 27	
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W 124	<p>Continued From page 5</p> <p>b. Client #2's records did not show evidence that his sister had received an explanation of his health condition(s) and treatment plans, including psychotropic medications and/or the right to refuse treatment.</p> <p>c. On December 5, 2008, at approximately 6:28 PM, interview with the current QMRP revealed that he had not reviewed Client #2's health, developmental and/or behavioral status with the sister, either in person or over the telephone, since he was appointed in September 2008.</p> <p>d. The current QMRP stated that he had not discussed these matters with the sister and upon review of the former QMRP's monthly summaries from 2008, he acknowledged that there was no such review documented in the client's record.</p> <p>e. The current QMRP confirmed that Client #2's sister had not been in attendance at the April 11, 2008 ISP meeting and further indicated that the interdisciplinary team had not met again since April to review the status of his training and habilitation needs.</p> <p>2. On December 4, 2008, at 12:00 PM, review of Client #1's Nurse Progress Notes revealed that on July 17, 2008, his mother, who was his designated surrogate healthcare decision-maker, had refused to give consent for an increase in his daily dose of Depakote (from 500 mg twice daily to 750 mg twice a day). The progress note also indicated that she would consult with an attorney. Another progress note, dated July 22, 2008, documented that the mother had consented to the proposed increase. Further review of Client #1's psychotropic medications revealed that the Depakote had been increased again, effective</p>	W 124	<p>W 124</p> <p>The QMRP will review health plans and treatment plans with the individuals family members, guardians or attorneys at least quarterly, or in the event of any changes, immediate notification is mandated. The Clinical Manager will review the current status of all individuals in the weekly Manager's meeting to insure implementation of this procedure.</p> <p>In the event a new QMRP is hired, any new QMRP will contact each individuals family, Guardian or attorney and review current status and document each review in the client's record.</p>	12/18/08
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W 124	<p>Continued From page 6</p> <p>October 12, 2008. There was no evidence, however, that the facility contacted his mother to inform her of the most recent medication increase. In addition, the client's record did not reflect an updated consent form had been signed, since the previous increase in July 2008.</p> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, the Federal Deficiency Report dated February 21, 2008, included the following:</p> <p>On February 20, 2008, review of Client #4's Individual Support Plan (ISP), dated April 13, 2007, revealed the client functioned in the severe range of mental retardation cognitively and his adaptive skills tested in the profound range. His sister was the designated surrogate healthcare decision-maker due to his impaired ability to process information effectively. His medication regimen included Lithium Carbonate 300 mg twice a day, Trazodone 100 mg every evening, Paroxetine 20 mg and Zyprexa 5 mg every evening, among other medications and he received one-on-one staff support as part of his behavior management plan. Included in the ISP was a team recommendation to "maintain contact with the sister... she is available to provide pertinent information regarding his welfare..." Further review of the ISP revealed no evidence that the sister had been involved in the planning and/or review process (i.e. she had not attended meetings, there were no documented telephone calls or written communications, etc.).</p> <p>Client #4's records did not show evidence that his sister had received an explanation of his health</p>	W 124	see W 124 page 4 of 27	12/18/08
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W 124	<p>Continued From page 7</p> <p>condition(s) and/or given written consent for his treatment plan, including psychotropic medications.</p> <p>At approximately 1:27 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that he had not reviewed Client #4's health, developmental and/or behavioral status with the sister, either in person or over the telephone, since he was appointed QMRP in January 2008. He was unaware of what actions might have been taken by previous QMRPs. He did, however, acknowledge that there was no such review documented in the client's record. The sister's most recent documented visit to the facility was June 11, 2006.</p> <p>On February 20, 2008, Client #4's sister was interviewed by telephone, beginning at 1:37 PM. She verified that she had not attended ISP planning and development meetings. She confirmed that she was the designated healthcare decision-maker. Further interview revealed that the sole time that she had been contacted by the facility in recent months was when her brother had fluid in the lungs and she had given consent for diagnostic procedures. No one from the facility had reviewed the client's health, developmental and/or behavioral status with her. When asked if she was interested in knowing about her brother's medication regimen, she replied yes, and she would share the information with their siblings (who "all live out of town")... on February 20, 2008, at 2:22 PM, review of the April 2004 "Rights of Individuals" policy had revealed the following: a facility "designee will facilitate services relating to medical conditions and treatment being explained to the individual and/or his/her designee... this includes risks and benefits</p>	W 124	<p>W 124</p> <p>The QMRP will review health plans and treatment plans with the individuals family members, guardians or attorneys at least quarterly, or in the event of any changes, immediate notification is mandated to include any explanation of risks and benefits. The Clinical Manager will review the current status of all individuals in the weekly Manager's meeting to insure implementation of this procedure.</p>	12/18/08
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W 124	<p>Continued From page 8 of medications and/or procedural interventions."</p> <p>*****</p> <p>Previously, the January 10, 2008 findings included the following:</p> <p>Client #2 was observed during the evening medication pass on January 7, 2008 ... administered Chlorpromazine 150 mg by mouth. Interview with the Licensed Practical Nurse (LPN) ... revealed that Client #2 was prescribed the medication for behavior management. Review of the physician's order sheet (POS) dated December 1, 2007 ... revealed that Client #2 had diagnoses of Intermittent Explosive Disorder and Schizophrenia; Chronic Undifferentiated Type and was prescribed Chlorpromazine 150 mg by mouth twice a day and Lithium 150 mg every day for seven days. Lisinopril 5 mg. by mouth every day for behavior management. Interview with the Program Manager ... revealed that Client #2's mother was very involved in his life but is not the client's legal guardian. Review of Client #2's, psychological assessment ... the client did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.</p>	W 124	<p>see W 124 page 4 of 27</p>	
W 148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's</p>	W 148		

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W 148	<p>Continued From page 9</p> <p>parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record verification, the facility failed to consistently notify clients' family members or guardians of significant incidents involving injuries, for one of the four clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>On December 3, 2008, at approximately 9:33 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #4 had a court-appointed guardian. According to court documents, the guardian was appointed October 25, 2006 due to the client's impaired ability to process information effectively .</p> <p>At approximately 5:15 PM, review of Client #4's Medication Administration Records (MARs) revealed that he received treatment for a human bite in July 2008. According to a July 13, 2008 Nurse Progress Note, "Staff reported that individual was bitten by another individual; bite size middle of right forearm. Size 1/2 by 1/2 inches open wound with red tissue effacing. Wound cleansed...triple antibiotic ointment... bandage per MD's order... LPN Nurse and RN Nurse Supervisor made aware."</p> <p>According to the QMRP, the notification of clients' family or guardians following an injury should be documented on the incident report. However, there was no corresponding incident report for</p>	W 148	<p>W 148</p> <p>The QMRP will ensure proper notification of individual's family members, guardians, attorneys and other circle of support members in the event of any incident/injury of any kind. The QMRP will insure that incident reports are generated as the need may arise and all staff were re-in serviced on 12/16/08 on the importance of completing incident reports in a timely manner.</p> <p>W 148</p> <p>Incident management training was completed on 12/16/08 and training on incident management/reporting will occur on an ongoing basis monthly and as the need may arise. The QMRP will insure in the future that family members, guardian, Department of Health and nurses are notified in a timely manner in the event of any incident. The agency has put in place a policy/protocol on human bite dated 12/12/08; staff were in serviced on the protocol on 12/16/08.</p>	<p>12/16/08</p> <p>12/16/08</p>
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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>	
(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 148	<p>Continued From page 10</p> <p>this bite incident. Further review of the client's records, including a detailed account of all contacts between the guardian and the facility (submitted by the guardian to the court), failed to show evidence that the guardian was notified of the July 13, 2008 bite incident.</p> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, in a February 21, 2008 Federal Deficiency Report, the facility was cited for failure to inform another client's sister/ designated surrogate healthcare decision-maker, as follows: "...the client functioned in the severe range of mental retardation cognitively and his adaptive skills tested in the profound range. His sister was the designated surrogate healthcare decision-maker... ... on January 21, 2008, he was sent to an emergency room (ER) 'for evaluation secondary to human bite... need tetanus' shot.' The client subsequently received the tetanus shot and began a 5-day antibiotic treatment, Biaxin 500 mg twice daily. At approximately 12:05 PM, review of the corresponding incident report revealed no indication that the client's sister had been notified. ... interview with the recently-assigned Qualified Mental Retardation Professional (QMRP) revealed that he had left a telephone message for the sister after the January 20, 2008 bite incident and subsequent emergency room visit. Upon examination of the incident report, however, the QMRP acknowledged that the alleged telephone call had not been documented on the incident report. When asked if the call had been documented elsewhere, he replied no. He said that he would (only) document the call/notification</p>	W 148	<p>W 148</p> <p>The Clinical Manager instituted mandatory attendance for nursing staff at weekly Managers' meetings and the RN in-serviced all nursing staff on notification of the QMRP or Clinical Manager for each incident report written.</p>	12/16/08

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W 148	<p>Continued From page 11 in the designated space on the incident report. On February 20, 2008, Client #4's sister (and surrogate healthcare decision-maker) was interviewed by telephone... To her knowledge, Client #4 had not been to an emergency room since he was admitted to this facility in March 2006... ...review of the April 2004 "Incident Management" policy revealed the following: 'All incidents will be handled appropriately and promptly, to include... timely and accurate notification of appropriate staff, families, guardians...' There was no evidence, however, that Client #4's sister received timely notification of the bite incident and subsequent treatment that he received.</p> <p>On March 27, 2008, the facility submitted a Plan of Correction that included the following: "ILS will ensure that individuals family &lt;sic&gt; are informed of all medical related incidents..."</p>	W 148	See W 148 Page 10 of 27	12/16/08
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to establish and implement policies to ensure the health and safety of the four clients residing in the facility.</p> <p>The findings include:</p> <p>1. Cross-refer to W148. The facility failed to consistently inform family members and/or guardians of incidents that place clients' health or</p>	W 149	See W 149 Page13	12/16/08



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W 149	<p>Continued From page 13</p> <p>himself and others. The BSP indicated a history of biting behavior that began years before he was admitted to this facility in March 2006. The most recent documented bite was to his own arm, in August 2008.</p> <p>On December 4, 2008, beginning at 12:18 PM, interviews with the recently-hired Qualified Mental Retardation Professional (QMRP), recently-hired LPN Coordinator and newly-hired Registered Nurse revealed that there was no established policy on handling human bites. At 12:38 PM, the RN stated that their recently-hired Clinical Director and the CEO were reviewing the agency's policies at the corporate office to determine whether there was an established bite protocol. At 2:39 PM, the RN presented an OSHA policy regarding exposure to blood-borne pathogens. The policy, however, addressed (only) the risks presented to the biter if the other individual's skin was broken. On December 5, 2008, the PCP brought a written statement to the facility that indicated that whether to send a client to the ER after a human bite would be "based on the information provided by the primary nurse," including "the site of the bite, depth of the bite..." The statement also referred to CDC immunization standards, as attached. Review of the standards revealed a CDC recommendation to receive tetanus boosters every 10 years.</p> <p>The statement, dated December 4, 2008, did not identify the anticipated/ appropriate response time re: nurse assessment of the bite wound and PCP notification. In addition, it did not define the term "primary nurse." Further discussions with the LPN and newly-hired RN failed to clarify why one client would receive prophylactic antibiotic treatment while another would not, when there</p>	W 149	<p>See W 104 #2 Page 2 of 27</p>	<p>12/12/08</p> <p>12/16/08</p>
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W 149	Continued From page 14 was evidence of a skin break. There was no evidence that the facility had established a policy on human bites prior to this survey.  It should be noted that the July 13, 2008 bite incident had not been investigated and review of Client #4's records failed to show evidence that the facility had sought to determine whether the client's wound received timely assessment by a trained medical professional.  It should be further noted that during the December 8, 2008 Exit teleconference, the facility's Clinical Director stated "we take them to the ER, period. That is our policy." This policy, however, had not been conveyed during the survey.	W 149	See W 104 #2 Page 2 of 27	12/12/08  12/16/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse were reported immediately to the administrator and to other officials in accordance with State Law as required by DC regulation (22 DCMR Chapter 35 Section 3519.10), for one of the four clients residing in the facility. (Client #4)  The finding includes:	W 153	see W 153 page 16 if 27	12/12/08  12/16/08

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W 153	<p>Continued From page 15</p> <p>On December 3, 2008, at approximately 5:15 PM, review of Client #4's Medication Administration Records (MARs) revealed that he received treatment for a human bite in July 2008. According to a July 13, 2008 Nurse Progress Note, "Staff reported that individual was bitten by another individual; bite size middle of right forearm. Size 1/2 by 1.2 inches open wound with red tissue effacing. Wound cleansed...triple antibiotic ointment... bandage per MD's order... LPN Nurse and RN Nurse Supervisor made aware." Further review of the record revealed that Client #1 had bitten Client 4.</p> <p>A pre-survey review of incident reports had shown documentation that Client #1 had bitten Client #3 on January 20, 2008 and bitten Client #2 on April 24, 2008. There was no incident report, however, for the July 13, 2008 bite involving Client #4.</p> <p>On December 4, 2008, beginning at 10:40 AM, another review of incident reports in the facility revealed no evidence that the July 13, 2008 bite was reported in accordance with facility policies. At 12:18 PM, the recently-assigned QMRP stated that the notification of their administrator and governmental officials following an incident was documented on the incident report. However, there was no evidence that an incident report was prepared for this bite (peer-on-peer abuse). The QMRP and the recently-assigned LPN Coordinator indicated that neither was previously aware of the July 13, 2008 bite incident that went unreported. Further review of the client's records and interview with the Incident Management Coordinator later that afternoon failed to show evidence that the administrator and the Health Regulation Administration were notified of the July 13, 2008 bite incident.</p>	W 153	<p>W 153 The QMRP will insure that incident reports are completed in a timely manner and all notifications are made appropriately.</p> <p>Incident management training was completed on 12/16/08 and training on incident management/reporting will occur on an ongoing basis monthly and as the need may arise. The QMRP will insure in the future that family members, guardian, Department of Health and nurses are notified in a timely manner in the event of any incident. The agency has put in place a policy/protocol on human bite dated 12/12/08; staff were in serviced on the protocol on 12/16/08.</p> <p>W 153 Client #2 immunization record is up to date tetanus shot was given on 8/9/99, good for ten years. Client #2 was taken to the emergency room for treatment for the incident of 7/08. The medical team will follow the established protocol/policy on human bite and will insure consistency in medical treatment to all individuals in the event of a human bite.</p>	<p>12/16/08</p> <p>12/16/08</p>



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W 154	<p>Continued From page 17</p> <p>staff, including nurses, following the bite to determine whether Client #2 received timely medical evaluation and referral for treatment.</p> <p>2. Cross-refer to W153. According to Client #4's July 2008 Medication Administration Record and a July 13, 2008 Nurse Progress Note, Client #4 was bitten on the forearm by a peer. The only staff documented as having knowledge of the bite incident were medical (nurses and the primary care physician). There was no evidence that an incident report was prepared and no evidence that the facility conducted a thorough investigation.</p> <p>It should be noted that the Nurse Progress Note was entered at 7:40 PM; however, there was no documentation here or elsewhere to determine the time that the bite actually occurred and/or whether the client received timely assessment of the wound by a licensed medical professional.</p>	W 154	<p>W 154 Client #2 immunization record is up to date, reflecting (tetanus shot) given 8/9/99, good for ten years He was taken to the emergency room for treatment on the day of the incident of 7/08. The medical team will follow the established protocol/policy on human bite and will insure consistency in medical treatment to all individuals in the event of a human bite.</p> <p>The QMRP/Nurses will insure that incident reports are generated whenever an incident occurs. All staff were re-in serviced on 12/16/08 on the importance of completing incident reports in a timely manner. In addition The Clinical Manager will review all incident reports immediately and each QMRP will report/discuss all incidents in the weekly managers meeting. Recommendations/ implementation on all incidents will be reviewed in the weekly managers meeting to insure regulatory compliance of investigation protocol. The agency's Clinical Manager, QMRP's and House Managers are scheduled to attend DDS Incident Management Training on 2/18/09 and 3/04/09 respectively. In addition the Clinical Manager and the Incident Manager will attend Incident Management level I certification training on 3/25/09.</p>	12/16/08
W 262	<p>483.440(f)(3)(I) PROGRAM MONITORING &amp; 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 staff interview and review of the facility's Human Rights Committee (HRC) minutes, the HRC failed to monitor increases and the addition of new medications, for two of the two clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p>	W 262	<p>W 262 Client #2 immunization record is up to date, reflecting (tetanus shot) given 8/9/99, good for ten years He was taken to the emergency room for treatment on the day of the incident of 7/08. The medical team will follow the established protocol/policy on human bite and will insure consistency in medical treatment to all individuals in the event of a human bite.</p> <p>The QMRP/Nurses will insure that incident reports are generated whenever an incident occurs. All staff were re-in serviced on 12/16/08 on the importance of completing incident reports in a timely manner. In addition The Clinical Manager will review all incident reports immediately and each QMRP will report/discuss all incidents in the weekly managers meeting. Recommendations/ implementation on all incidents will be reviewed in the weekly managers meeting to insure regulatory compliance of investigation protocol. The agency's Clinical Manager, QMRP's and House Managers are scheduled to attend DDS Incident Management Training on 2/18/09 and 3/04/09 respectively. In addition the Clinical Manager and the Incident Manager will attend Incident Management level I certification training on 3/25/09.</p>	1/30/09

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W 262	Continued From page 18  The facility's HRC had documented meetings held on May 8, 2008, August 20, 2008 and November 19, 2008. However,  1. On December 3, 2008, at 8:10 AM, Client #1 was observed to receive Divalproex (Depakote) DR 500 mg Tab, 2 tabs (1000 mg) by mouth. Interview with the medication nurse at 8:15 AM revealed that this medication was prescribed to help manage the client's aggressive behavior. Shortly after the December 3, 2008 medication pass observation, review of Client #1's physician's orders (POs) on December 3, 2008 at 8:50 AM revealed that he received the Depakote twice daily. Continued review of his POs revealed that he had been receiving 750 mg twice daily (1500 mg) until the order was changed October 12, 2008 to 1000 mg twice daily (2000 mg). On December 5, 2008, at 5:40 PM, interview with the Qualified Mental Retardation, followed by a review of the HRC minutes, dated November 19, 2008, revealed no evidence that the 33% increase in Depakote had been reviewed and approved by the HRC.  2. Client #2's December 2008 physician's orders (POs) indicated that his medication regimen included Abilify 30 mg and Lexapro 20 mg every morning, among other medications. In addition, the client received one-on-one staff support as part of his behavior management plan. Further record review revealed that the daily dose of Lexapro had been doubled (from 10 mg to 20 mg) and the Abilify had been introduced in October 2008. There was no evidence, however, that these (and concurrent) changes in his psychotropic medication regimen had been reviewed by the HRC.	W 262	W 262  ILS Human Rights Committee will convene on 1/21/09 to re- approve the continuation of psychotropic medications treatment and continuation of the BSP. The Committee will, on a continuous basis, ensure updated records (approval for continued use of psychotropic medications and BSP's).	12/21/08

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W 263	<p><b>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</b></p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that programs which incorporate restrictive techniques, including the use of medications to control behaviors, were conducted only with the written informed consent of the client or legal guardian, for two of the two clients in the sample. (Client #1, and #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure informed consent for an increase in Client #1's psychotropic medication, as follows:</li> </ol> <p>Observation of the medication administration on December 3, 2008, at 8:10 AM, revealed Client #1 receiving Divalproex (Depakote) DR 500 mg Tab, 2 tabs (1000 mg by mouth). Interview with the medication nurse at 8:15 AM revealed that this medication was prescribed to be administered daily in conjunction with Lorazepam 2 mg BID, Trihexyphenidyl 2 mg (Artane), and Chlorpromazine (Thorazine) 50 mg, 3 tabs BID to help manage the client's aggression. She also indicated that the medications were used in conjunction with a behavior support plan (BSP).</p> <p>On December 4, 2008, at 5:40 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1's guardian had</p>	W 263	<p>W 263</p> <p>The QMRP will insure that all informed consents are obtained to address medication changes (psychotropic medications). Client #1's mother signed the informed consent form on 12/20/08 for psychotropic medication changes as prescribed by the psychiatrist on 10/22/08.</p>	12/20/08
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W 263	<p>Continued From page 20</p> <p>approved the use of the psychotropic medication. Subsequent review of his records revealed a consent form signed July 2008 that reflected a 750 mg dose of Depakote twice daily. Since then, however, the Depakote was increased 33%, to 100 mg twice daily, effective October 12, 2008. Further review of the record failed to show evidence of written informed consent from the mother for the October 2008 increase in Depakote.</p> <p>2. According to Client #2's psychological assessment, dated April 2008, Client #2 was diagnosed with severe mental retardation and was incapable of processing information effectively to make informed decisions. Client #2's Individual Support Plan (ISP), dated April 11, 2008, documented that his sister was the designated surrogate healthcare decision-maker. In addition, the client's diagnostic profile included intermittent explosive disorder and mood disorder, NOS.</p> <p>Client #2's behavior support plan (BSP), also dated April 11, 2008, included the use of psychotropic medications (Lexapro, Lorazepam, and Zyprexa) as well as the use of 1:1 staff supervision 16 hours daily (during awake hours). Further review of his record failed to show evidence that Client #2's sister had signed written consent for the use of medications and intensive (1:1) staff supervision.</p> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, the Federal Deficiency Report dated February 1, 2007, included the following:</p>	W 263	<p>W 263</p> <p>The HRC committee will meet immediately after the monthly psych review. The HRC will meet to approve/disapprove any changes in psychotropic medications, pending consent by guardian. The HRC will review the minutes from the previous meeting to identify any outstanding issues. In the event of telephone consent, written documentation will reflect verbal consent and a consent document will be immediately forwarded to the guardian/family member for signature. Once consent has been obtained and approval has been given by the committee, nursing staff will immediately implement any medication changes.</p> <p>W 263</p> <p>The QMRP will insure that client family members, guardians, attorneys, and other members of the individuals circle of support, will be informed of any medication changes (psychotropic medications) and informed consent will be obtained in a timely manner.</p>	<p>1/30/09</p> <p>12/18/08</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G212</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>	
(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 263	Continued From page 21  Based on staff interview and record review, the facility failed to ensure that programs, which incorporate restrictive techniques, were conducted only with the written informed consent of the client or legal guardian, for two of the two clients in the sample. (Clients #1 and #2)  The finding includes:  There was no evidence that the HRC had informed consent for the use of the behavior support plans that included the use of psychotropic medications. [See W124]	W 263	W 263 ILS Human Rights Committee will convene on 1/21/09 to re- approve the continuation of psychotropic medications treatment and continuation of the BSP. The Committee will, on a continuous basis, ensure updated records (approval for continued use of psychotropic medications and BSP's).	1/21/09
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: Based on staff interview and record review, the facility failed to ensure that clients received preventive and general medical care, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)  The findings include:  1. Cross-refer to W149.4. On December 4, 2008, review of incident reports revealed that Client #1 had bitten Clients #2 and #3, on January 20, 2008 and April 24, 2008, respectively. Client #4's medical record documented that he too was bitten by Client #1 on July 13, 2008. All of the aforementioned bites broke the skin. However, unlike previous bites, there was no evidence that Client #4 received assessment in an ER and	W 322		

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W 322	<p>Continued From page 22</p> <p>prophylactic antibiotic treatment. At the time of the survey, there was no evidence that the medical team had established a protocol for timely response to human bites.</p> <p>2. The facility's medical services failed to ensure timely implementation of the primary care physician's (PCP's) order that Client #1 receive an allergy evaluation to verify Haldol allergy.</p> <p>On December 4, 2008 at 4:10 PM, review of Client #1's annual medical evaluation, dated March 10, 2008, revealed a diagnosis of "Haldol Sensitivity." Review of a physician's order dated July 16, 2008 reflected a hand written order "Allergist to determine if allergic to Haldol." The July 16, 2008 physician's order (POs) also included "Haldol 5 mg IM (for psychotic aggression)".</p> <p>A pre-survey review of incident reports revealed that on September 4, 2008, at 2:40 PM, Client #1 received Haldol 5 mg (via intramuscular injection) while receiving treatment for an ear infection at a local hospital emergency room (ER). The group home's subsequent investigation of the incident revealed that the client's Health Passport which accompanied him to the ER, identified his allergy to Haldol. The investigation report indicated that once the error had been identified, the client was administered Benadryl to counteract the potential effects of the Haldol.</p> <p>Review of the December 1, 2008 POs revealed an order for "Haloperidol Lac 5mg/ml, give only on order of &lt;psychiatrist&gt; for extreme agitation." The same POs, however, also indicated that the client was allergic to Haloperidol.) On December 5, 2008 at 9:35 AM, interview with the designated</p>	W 322	<p>W 322</p> <p>ILS has in place a protocol to address all incidents of human bites. The medical team will ensure treatment of all bites in accordance with the Human Bite Protocol. (Emergency room treatment in the event of skin break)</p> <p>W 322</p> <p>The medical team will insure immediate response to all recommendations on behalf of our individuals. An appointment was scheduled with the allergy specialist on 1/6/09 for client #1. All recommendations will be followed appropriately.</p>	<p>12/12/08</p> <p>1/6/09</p>
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W 338	Continued From page 25  2. (Cross refer to W322.3.)The facility nursing services failed to ensure timely follow-up on Client #1's non-reactive Hepatitis B immunity as follows.  On December 3, 2008, at 12:25 PM, interview with Client #1's day program case manager revealed that on June 3, 2008, Client #1 bit a peer at his day program. The day program indicated that the peer's skin was broken during the bite and that he was a Hepatitis B carrier. The day program requested that Client #1 Hepatitis B status be assessed. Record review revealed the Client #1 was tested on January 8, 2008 and again on June 25, 2008 and was non-reactive both times. Client #1's immunization record documented that Hepatitis B vaccination (dose #3) had been administered on February 14, 2001. There was no evidence the client was referred timely for follow-up on his non-reactive status when tested for immunity to Hepatitis B.	W 338	W 338  The RN has mandated all consults for individuals be faxed to the office for weekly review at the Managers meeting or as the need occurs. The Clinical Manager has mandated that nursing will be represented weekly at the Managers meetings. All consults and recommendations will be reviewed weekly and recommended completion dates will be followed and documented.	12/18/08	
W 362	483.460(j)(1) DRUG REGIMEN REVIEW  A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the pharmacist provided drug regimen reviews at least quarterly for two of two clients in the sample. (Clients #1 and #2)  The findings include:  On December 5, 2008, at 2:45 PM, interview with	W 362	W 362  The RN has mandated all consults for individuals be faxed to the office for weekly review at the Managers meeting or as the need occurs. The Clinical Manager has mandated that nursing will be represented weekly at the Managers meetings. All consults and recommendations will be reviewed weekly and recommended completion dates will be followed and documented.	12/18/08	

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W 362	Continued From page 26 the designated LPN revealed that pharmacy reviews should be conducted quarterly to monitor the clients' medication regimens. At 3:05 PM, record review revealed that the pharmacist reviewed Client #1's medications on May 28, 2008 and on September 21, 2008, 4 months later. Similarly, there was a 4-month gap between Client #2's February 29, 2008 and June 24, 2008 pharmacy reviews. There was no evidence that the pharmacist consistently reviewed clients' medications at least quarterly.	W 362	W 362 Pharmacy reviews will be conducted every three months.. The agency will insure that pharmacy reviews are conducted every three months. The last review was conducted on 12/18/08	12/18/08
W 440	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct simulated fire drills at least quarterly on each shift.  The finding includes:  On December 5, 2008, at 12:50 PM, interview with the Qualified Mental Retardation Professional (QMRP) and review of the weekly staffing schedule indicated that there were primarily three designated shifts (8:00 AM - 4:00 PM; 4:00 PM - 12:00 PM; and 12:00 AM - 8:00 AM). Later that day, beginning at 12:55 PM, review of the facility's fire drill records revealed that only one drill (July 12, 2008) had been documented during the overnight shift (12:00 AM - 8:00 AM) since January 2008.	W 440	W 440 Fire Drill Calendars were updated to reflect drills monthly per shift and Fire Drill records were reviewed for implementation of 1 drill per shift per month. The Clinical Manager and QMRP's will review Fire Drill documentation monthly at the Managers meeting.  W 440 The QMRP will insure that fire drill evacuations are conducted as outlined in the Policy and Procedure Manual. Staff were re-in-service on 12/16/08 on the need to conduct fire drill evacuation as scheduled (monthly per shift). The QMRP will conduct weekly inspection of fire drill records to ensure staff compliance.	12/16/08

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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012
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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted on December 3, 2008 through December 5, 2008. Two residents were randomly selected for the sample from a residential population of four males with varying degrees of mental retardation.</p> <p>The findings of the survey were based on observations at the group home, interview with residential staff and day program staff, and the review of clinical and administrative records, including the review of the facility's unusual incident reports.</p>	I 000		
I 227	<p><b>3510.5(d) STAFF TRAINING</b></p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of the four residents of the facility. (Residents #1, #2, #3, and #4)</p> <p>The findings include:</p> <p>During the December 3, 2008 Entrance Conference, at approximately 8:40 AM, the Qualified Mental Retardation Professional (QMRP) stated that all staff were expected to maintain current Cardiopulmonary Resuscitation (CPR) certification and First Aid training.</p>	I 227	<p>I 227</p> <p>The Clinical manager reviewed all CPR/1<sup>st</sup> Aid, fire and disaster plans and implemented training sessions for all individuals.</p> <p>Fire Drill Calendars were updated to reflect drills monthly per shift and Fire Drill records were reviewed for implementation of 1 drill per shift per month. The Clinical Manager and QMRP's will review Fire Drill documentation monthly at the Managers meeting.</p>	12/18/08

Health Regulation Administration

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

*[Signature]*  
LARRY FOLK

TITLE *[Signature]* 02/12/09  
CLINICAL MANAGER

STATE FORM

CFVM11

If continuation sheet 1 of 2

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0206</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2008</b>
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I 227	<p>Continued From page 1</p> <p>On December 5, 2008, beginning at approximately 2:00 PM, review of staff and consultant records revealed the following:</p> <ol style="list-style-type: none"> <li>1. There was no documented evidence of current CPR certification training for 5 of the 15 direct support staff (S1, S2, S3 and S4 and S5).</li> <li>2. There was no documented evidence of CPR certification for N1.</li> <li>3. There was no documented evidence of CPR certification and First Aid training available for:               <ol style="list-style-type: none"> <li>a. the Residential Manager,</li> <li>b. the Qualified Mental Retardation Professional.</li> </ol> </li> <li>4. There was no documented evidence of First Aid training for 2 of the 15 direct support staff (S4 and S5).</li> </ol> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, the Licensure Statement of Deficiencies, dated January 10, 2008, included the following:</p> <p>On January 9, 2008... the following staffs and consultants was without current First Aid and CPR, or both.</p> <ol style="list-style-type: none"> <li>1. Current CPR - S #4, #5, #11, #12, #13 and #14</li> <li>2. First Aid - S #4, #5, #11, #12 #13 and #14</li> </ol>	I 227	<p>I 227</p> <p>ILS Human Resources Department will insure that all staff are CPR and 1<sup>st</sup> aid certified at all times. First Aid and CPR training was scheduled for 12/29-31<sup>st</sup> 2008. The HR department will ensure maintenance of proper certification of First Aid/CPR for all employees.</p> <p>The Clinical Manager instituted a spread sheet including all staff certifications and trainings to be reviewed monthly. Notification of certification needs will be directed to appropriate staff via letters attached to pay checks. Any individuals not meeting certification standards will be removed from the schedule until completion of certification is completed.</p>	12/31/08
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I 292	Continued From page 2	I 292		
I 292	<p>3514.3 RESIDENT RECORDS</p> <p>Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.).</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain resident records in accordance with requirements of D.C. Law 2-137 (now Title 7, Chapter 13), for two of the four residents of the facility. (Residents #1 and #4)</p> <p>The findings include:</p> <p>Title 7, Chapter 13; D.C. Code 7-1305.12 (formerly 6-1972) Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include:</p> <p>(9) "A summary of each significant contact by a professional person with a customer"</p> <p>The facility failed to ensure a summary of treatment received during each dental consultation was provided to the group home for Resident #1.</p> <p>On December 4, 2008, at 12:25 PM, interview with the designated LPN revealed that Resident #1 had recently been to the dentist and was awaiting authorization of funding for restorative treatment services. Subsequent review later that day of the resident's dental records revealed a March 12, 2008 dental report that failed to document what, if any, assessment and/or treatment services were rendered. The March</p>	I 292	<p>I 292</p> <p>The QMRP will document all contacts related to individuals in monthly notes. The Clinical manager will randomly review and cross reference contacts with individuals and appropriate documentation on a monthly basis for each individual.</p> <p>The RN has mandated all consults for individuals be faxed to the office for weekly review at the Managers meeting or as the need occurs. The Clinical Manager has mandated that nursing will be represented weekly at the Managers meetings.</p> <p>ILS will insure that all customer records are made available to the circle of support and all staff workers who are directly involved, effective immediately.</p> <p>I 292 Complete consultation entries regarding treatment (dental) have been requested as of 1/6/09. Nursing services will ensure that regular dental follow-up appointments are completed as ordered/indicated. Client #1 has a dental appointment Has been scheduled for 3/10/09.</p>	<p>12/18/08</p> <p>1/6/09</p>

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I 292	<p>Continued From page 3</p> <p>12, 2008 report reflected a recommendation that he return on April 2, 2008. The dentist had not, however, indicated the reasoning or "findings" that led to the recommendation to return 3 weeks later. On December 5, 2008, at 3:40 PM, further interview with the designated LPN revealed that the type of services rendered to the resident on March 12, 2008 had not been verified.</p> <p>It should be noted that he did return to the dentist on April 2, 2008. And on November 17, 2008, the resident was diagnosed with periodontitis, halitosis and multiple carious lesions (teeth #22, #23 and #27).</p> <p>(16) "A record of any seizures, illnesses, treatments thereof, and immunizations."</p> <p>The facility failed to ensure that current documentation of Resident #4's tetanus booster shot was maintained in his health record.</p> <p>On December 4, 2008, at 1:40 PM, review of Resident #4's immunology history/record sheet in his medical chart revealed that the most recent tetanus-diphtheria shot he had received was given on July 23, 1998. It further indicated that he was due for another booster shot in July 2008. Continued review of Resident #4's record revealed no evidence, however, that he had received the 10-year tetanus booster shot.</p> <p>On December 4, 2008, at approximately 3:25 PM, interview with an LPN revealed that someone within the agency had informed her that Resident #4 had in fact received a tetanus booster. She acknowledged, however, that the alleged tetanus booster was not reflected in the resident's medical chart. The following afternoon (December 5, 2008), the LPN presented a</p>	I 292	<p>I 292</p> <p>Complete consultation entries regarding treatment (dental) have been requested as of 1/6/09. Nursing services will ensure that regular dental follow-up appointments are completed as ordered/indicated. Client #1 has a dental appointment Has been scheduled for 3/10/09.</p> <p>I 292</p> <p>Immunization records will be maintained/reviewed by nursing staff monthly and will be reviewed by the Primary Care Physician annually.</p>	<p>1/6/09</p> <p>12/18/08</p>
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I 292	Continued From page 4  document that she had received just minutes earlier via fax transmittal from a hospital clinic, verifying that Resident #4 had received a diphtheria-tetanus booster on December 18, 2006. The LPN acknowledged that the facility had not maintained current immunology records for Resident #4.	I 292	I 292  The QMRP will review health plans and treatment plans with the individuals family members, guardians or attorneys at least quarterly, or in the event of any changes, immediate notification is mandated. The Clinical Manager will review the current status of all individuals in the weekly Manager's meeting to insure implementation of this procedure.  In the event a new QMRP is hired, any new QMRP will contact each individuals family, Guardian or attorney and review current status and document each review in the client's record.	12/18/08
I 374	<b>3519.5 EMERGENCIES</b>  After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident.  This Statute is not met as evidenced by: Based on interviews and record verification, the facility failed to consistently notify residents' family members or guardians of significant incidents involving injuries, for one of the four residents residing in the facility. (Resident #4)  The finding includes:  On December 3, 2008, at approximately 9:33 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #4 had a court-appointed guardian. According to court documents, the guardian was appointed October 25, 2006 due to the resident's impaired ability to process information effectively .  At approximately 5:15 PM, review of Resident #4's Medication Administration Records (MARs) revealed that he received treatment for a human bite in July 2008. According to a July 13, 2008	I 374	I 374  The QMRP will insure that all informed consents are obtained to address medication changes (psychotropic medications). Client #1's mother signed the informed consent form on 12/20/08 for psychotropic medication changes as prescribed by the psychiatrist on 10/22/08.	12/20/08

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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>		
(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
I 374	<p>Continued From page 5</p> <p>Nurse Progress Note, "Staff reported that individual was bitten by another individual; bite size middle of right forearm. Size 1/2 by 1/2 inches open wound with red tissue effacing. Wound cleansed...triple antibiotic ointment... bandage per MD's order... LPN Nurse and RN Nurse Supervisor made aware."</p> <p>According to the QMRP, the notification of residents' family or guardians following an injury should be documented on the incident report. However, there was no corresponding incident report for this bite incident. Further review of the resident's records, including a detailed account of all contacts between the guardian and the facility (submitted by the guardian to the court), failed to show evidence that the guardian was notified of the July 13, 2008 bite incident.</p> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, in a February 21, 2008 Federal Deficiency Report, the facility was cited for failure to inform another resident's sister/ designated surrogate healthcare decision-maker, as follows: "...the resident functioned in the severe range of mental retardation cognitively and his adaptive skills tested in the profound range. His sister was the designated surrogate healthcare decision-maker... on January 21, 2008, he was sent to an emergency room (ER) 'for evaluation secondary to human bite... need tetanus' shot.' The resident subsequently received the tetanus shot and began a 5-day antibiotic treatment, Biaxin 500 mg twice daily. At approximately 12:05 PM, review of the corresponding incident report revealed no indication that the resident's sister had been</p>	I 374	<p>I 374</p> <p>The QMRP will ensure proper notification of individual's family members, guardians, attorneys and other circle of support members in the event of any incident/injury of any kind.</p>	12/18/08

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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>		
(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
I 374	Continued From page 6 notified. ... interview with the recently-assigned Qualified Mental Retardation Professional (QMRP) revealed that he had left a telephone message for the sister after the January 20, 2008 bite incident and subsequent emergency room visit. Upon examination of the incident report, however, the QMRP acknowledged that the alleged telephone call had not been documented on the incident report. When asked if the call had been documented elsewhere, he replied no. He said that he would (only) document the call/notification in the designated space on the incident report. On February 20, 2008, Resident #4's sister (and surrogate healthcare decision-maker) was interviewed by telephone... To her knowledge, Resident #4 had not been to an emergency room since he was admitted to this facility in March 2006... ...review of the April 2004 "Incident Management" policy revealed the following: 'All incidents will be handled appropriately and promptly, to include... timely and accurate notification of appropriate staff, families, guardians...' There was no evidence, however, that Resident #4's sister received timely notification of the bite incident and subsequent treatment that he received.  On March 27, 2008, the facility submitted a Plan of Correction that included the following: "ILS will ensure that individuals family <sic> are informed of all medical related incidents..."	I 374	I 374  All incident reports will be reviewed weekly in the Managers meeting to insure notification of guardians and families of any incidents. The Clinical Manager has instituted a policy that any individual health changes be reported immediately to the Clinical Manager to insure prompt notification of families and guardians. All incident reports will faxed to the office be reviewed by the Clinical manager to insure appropriate documentation and notification.	12/18/08
I 379	3519.10 EMERGENCIES  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living	I 379		



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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>		
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I 379	Continued From page 8  2008 bite involving Resident #4 had been received.  On December 4, 2008, beginning at 10:40 AM, another review of incident reports in the facility revealed no evidence that the July 13, 2008 bite was reported on an incident report, in accordance with facility policies. At 12:18 PM, the recently-assigned QMRP stated that the notification of governmental officials following an incident should be documented on the incident report. However, there was no evidence that an incident report was prepared for this bite (peer-on-peer abuse). The QMRP and the recently-assigned LPN Coordinator indicated that neither was previously aware of the July 13, 2008 bite incident that went unreported. Further review of the resident's records and interviews with the Incident Management Coordinator later that afternoon failed to show evidence that the Health Regulation Administration was notified of the July 13, 2008 bite incident.	I 379	I 370  The Clinical manager will review all incidents and responses by the Incident Manager and insure proper notification of the Health Regulation Administration is completed. All staff have been in-serviced on incident management .	12/16/08
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 staff interview and record review, the facility failed to ensure that residents received preventive and general medical care, for two of the four residents living in the facility. (Residents #1 and #4)	I 401		

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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>
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I 401	<p>Continued From page 9</p> <p>The findings include:</p> <p>1. The facility failed to establish and implement a policy or protocol to ensure timely and appropriate response to human bites.</p> <p>A December 4, 2008 review of incident reports and resident records revealed a number of incidents where Resident #1 bit himself or his peers. For example, Resident #1 bit Resident #3 on his hand on January 20, 2008. He also bit Resident #2 on the arm on April 24, 2008. Resident #2 was sent to an emergency room where he received a tetanus booster and began a 10-day regimen of Augmentin (antibiotic) as a prophylactic. Resident #4's record documented that on July 13, 2008, he too was bitten by Resident #1. However, instead of going to an ER for evaluation and treatment, the PCP instructed the nurse to cleanse the wound with normal saline solution and apply triple antibiotic ointment. Unlike Residents #2 and #3, Resident #4 did not receive prophylactic antibiotics. Resident #1's behavior support plan (BSP), dated April 11, 2008, reflected 3 target behaviors, including biting himself and others. The BSP indicated a history of biting behavior that began years before he was admitted to this facility in March 2006. The most recent documented bite was to his own arm, in August 2008.</p> <p>On December 4, 2008, beginning at 12:18 PM, interviews with the recently-hired Qualified Mental Retardation Professional (QMRP), recently-hired LPN Coordinator and newly-hired Registered Nurse revealed that there was no established policy on handling human bites. At 12:38 PM, the RN stated that their recently-hired Clinical Director and the CEO were reviewing the agency's policies at the corporate office to</p>	I 401	<p>I 401</p> <p>The Human Bite Protocol addresses the issue of immediate response to all incident of human bite. Incidents of human bite will be treated at the emergency room. (In case of skin break) The Nurses and PCP will be notified immediately. Implementation (including in service training) provided by the nursing staff on 12/16/08.</p> <p>ILS has implemented a Human Bite Policy and Protocol as of 12/12/08, to address any type of human bite as it may occur.</p> <p>The Human Bite Protocol addresses the issue of immediate response to all incident of human bite. Incidents of human bite will be treated at the emergency room. (In case of skin break) The Nurses and PCP will be notified immediately. Implementation (including in service training) provided by the nursing staff on 12/16/08.</p>	<p>12/12/08</p> <p>12/12/08</p> <p>12/16/08</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0206</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>		
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I 401	<p>Continued From page 10</p> <p>determine whether there was an established bite protocol. At 2:39 PM, the RN presented an OSHA policy regarding exposure to blood-borne pathogens. The policy, however, addressed (only) the risks presented to the biter if the other individual's skin was broken. On December 5, 2008, the PCP brought a written statement to the facility that indicated that whether to send a resident to the ER following a human bite would be "based on the information provided by the primary nurse," including "the site of the bite, depth of the bite..." The statement also referred to CDC immunization standards, as attached. Review of the standards revealed a CDC recommendation to receive tetanus boosters every 10 years.</p> <p>The statement, dated December 4, 2008, did not identify the anticipated/ appropriate response time re: nurse assessment of the bite wound and PCP notification. In addition, it did not define the term "primary nurse." Further discussions with the LPN and newly-hired RN failed to clarify why one resident would receive prophylactic antibiotic treatment while another would not, when there was evidence of a skin break. There was no evidence that the facility had established a policy on human bites prior to this survey.</p> <p>2. The facility's medical services failed to ensure timely follow-up on the primary care physician's (PCP's) order that Resident #1 receive an allergy evaluation to verify Haldol allergy.</p> <p>On December 4, 2008, at 4:10 PM, review of Resident #1's annual medical evaluation, dated March 10, 2008, revealed a diagnosis of "Haldol Sensitivity." Review of a physician's order dated July 16, 2008 reflected a hand written order "Allergist to determine if allergic to Haldol." The</p>	I 401	<p>I 401 See I 401 Page 10 of 20</p>	

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I 401	<p>Continued From page 11</p> <p>July 16, 2008 physician's order also included "Haldol 5 mg IM (for psychotic aggression)".</p> <p>A pre-survey review of incident reports revealed that on September 4, 2008, at 2:40 PM, Resident #1 received Haldol 5 mg (via intramuscular injection) while receiving treatment for an ear infection at a local hospital emergency room. The group home's subsequent investigation of the incident revealed that the resident's Health Passport, which accompanied him to the ER, identified his allergy to Haldol. The investigation report indicated that once the error had been identified, the resident was administered Benadryl to counteract the potential effects of the Haldol.</p> <p>Review of the December 1, 2008 POs revealed an order for "Haloperidol Lac 5mg/ml, give only on order of &lt;psychiatrist&gt; for extreme agitation." The same POs, however, also indicated that the resident was allergic to Haloperidol.) On December 5, 2008 at 9:35 AM, interview with the designated LPN confirmed that the Haldol allergy evaluation had not yet been completed, nor had it been scheduled to date. Later that morning, the LPN informed this surveyor that she scheduled a Haldol-allergy evaluation for January 6, 2009. Subsequent record review verified that at the time of the survey, there was no evidence the allergy assessment prescribed by the PCP in July 2008 to "determine if allergic to Haldol" had been performed.</p> <p>3. The facility failed to refer Resident #1 for Hepatitis B immunization timely, after a January 8, 2008 test indicated his non-reactive (unprotected) status, as follows.</p> <p>On December 3, 2008, at 12:25 PM, interview with Resident #1's day program case manager</p>	I 401	<p>1401</p> <p>The medical team will insure immediate response to all recommendations on behalf of our individuals. An appointment was scheduled with the allergy specialist on 1/6/09 for client #1. All recommendations will be followed appropriately.</p> <p>The RN has mandated all consults for individuals be faxed to the office for weekly review at the Managers meeting or as the need occurs. The Clinical Manager has mandated that nursing will be represented weekly at the Managers meetings. All consults and recommendations will be reviewed weekly and recommended completion dates will be followed and documented.</p>	<p>1/6/09</p> <p>12/18/08</p>

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I 401	<p>Continued From page 12</p> <p>revealed that on June 3, 2008, he bit one of his peers. Review of a day program referral FER (for evaluation and review form) indicated that the group home would be notified and that the FER would be sent to the group home. Review of the FER at the day program revealed that it included a request for verification of Resident #1's Hepatitis immunization status, as the other resident's skin had been broken. Additional review of the FER indicated that the resident who was bitten by Resident #1 was a Hepatitis B carrier.</p> <p>On December 5, 2008, at 2:40 PM, review of Resident #1's immunization record in the home indicated that a Hepatitis B vaccination, dose #3, previously had been administered on February 14, 2001. Seven years later, on January 8, 2008, lab tests indicated that his status was non-reactive, however the record failed to reflect further instructions on how to address the resident's non-reactive status at that time. On June 25, 2008, another test again showed that Resident #1 was non-reactive. A new series of Hepatitis vaccinations was initiated on on July 15, 2008.</p> <p>Further review of the resident's immunization record revealed that it included a statement that his hepatitis immunity status should be assessed every five years (in accordance with Centers for Disease Control (CDC) and Prevention guidelines). Testing therefore had been due February 2006. There was no evidence that Resident #1's hepatitis immunity status was tested every 5 years. In addition, the facility failed to provide timely response to the resident's January 8, 2008 tests that indicated his non-reactive status.</p>	I 401	<p>I 401</p> <p>Resident # 1 Hepatitis B series has been initiated and will be completed on 2/27/08.</p> <p>.....</p> <p>Immunization records will be maintained/reviewed by nursing staff monthly and will be reviewed by the Primary Care Physician annually.</p>	12/18/08

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NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOLUTIONS, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>
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I 500	Continued From page 13	I 500		
I 500	<p><b>3523.1 RESIDENT'S RIGHTS</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP 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) that governs the care and rights of persons with mental retardation.</p> <p>The findings include:</p> <p>1. The facility failed to protect residents' rights to receive prompt and adequate medical attention [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)], as follows:</p> <p>Cross-refer to I401. The facility failed to:</p> <p>a. refer Resident #1 to an allergist timely and in accordance with his primary care physician's order;</p> <p>b. establish and implement a policy or protocol to ensure timely and appropriate response to human bites; and,</p> <p>c. refer Resident #1 for Hepatitis B immunization timely, after a January 8, 2008 test indicated his non-reactive (unprotected) status.</p>	I 500	<p>I 500 The Human Bite Protocol addresses the issue of immediate response to all incident of human bite. Incidents of human bite will be treated at the emergency room. (In case of skin break) The Nurses and PCP will be notified immediately. Implementation (including in service training) provided by the nursing staff on 12/16/08.</p> <p>I 500 Nursing staff will review consult recommendations as they occur and inform the Primary Care Physician. The medical team will insure immediate response to all recommendations o behalf of our individuals. An appointment was scheduled with the allergy specialist for 1/6/09 and rescheduled for 2/13/09 for client #1. All recommendations will be followed appropriately.</p>	<p>12/12/08</p> <p>1/6/09</p>

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I 500	Continued From page 14  2. The facility failed to demonstrate protection of residents' rights to be free from unnecessary or excessive medication; specifically, psychotropic medications. [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows:  a. Cross-refer to Federal Deficiency Report - Citations W124 and W263. Based on interview and record review, the facility failed to establish a system to ensure that Resident #2's designated surrogate healthcare decision-maker was informed of the benefits and risks of medications and of the right to refuse treatment. Resident #2's Individual Support Plan (ISP), dated April 11, 2008, revealed that the resident functioned in the severe range of mental retardation in cognitive and adaptive skills. The ISP indicated that his sister was the designated surrogate healthcare decision-maker due to his impaired ability to process information effectively. His December 2008 physician's orders (POs) indicated that his medication regimen included Abilify 30 mg every morning, Lexapro 20 mg every morning, Lorazepam 1 mg twice daily and Zyprexa 10 mg every morning, among other medications. However,  (1) there was no evidence that the sister had been involved in the planning and/or review process (i.e. she had not attended meetings, there were no documented telephone calls or written communications, etc.);  (2) his records did not show evidence that his sister had received an explanation of his health condition(s), treatment plan, including psychotropic medications, and right to refuse treatment; and,  (3) there was no evidence that the sister had	I 500	I 500  Client # 1 Hepatitis B series Is in progress and will be Completed 2/27/09  W 263 See page 22 of of 2  W 124 See page 4 of 27  1500  The QMRP will review health plans and treatment plans with the individuals family members, guardians or attorneys at least quarterly, or in the event of any changes, immediate notification is mandated to include any explanation of risks and benefits. The Clinical Manager will review the current status of all individuals in the weekly Manager's meeting to insure implementation of this procedure.	2/27/09  1/29/09  12/18/08  12/18/08

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I 500	<p>Continued From page 15</p> <p>provided written consent for intrusive behavior management methods, including psychotropic medications and 1:1 staffing.</p> <p>The QMRP confirmed that Resident #2's sister had not been in attendance at the April 11, 2008 ISP meeting, and acknowledged that there was no evidence that his sister had been informed of the resident's health status and treatment options. In addition, the QMRP indicated that the interdisciplinary team had not met again since April; and,</p> <p>b. Cross-refer to W263. Resident #1's mother was his designated surrogate healthcare decision-maker. On October 12, 2008, the resident's Depakote was increased by 33%. There was no evidence, however, that the facility contacted his mother to inform her of the recent medication increase. In addition, the resident's record did not reflect an updated consent form had been signed.</p> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, the Federal Deficiency Report dated February 21, 2008, included the following:</p> <p>... Resident #4's Individual Support Plan (ISP), dated April 13, 2007, revealed the resident functioned in the severe range of mental retardation cognitively and his adaptive skills tested in the profound range. His sister was the designated surrogate healthcare decision-maker due to his impaired ability to process information effectively. His medication regimen included Lithium Carbonate 300 mg twice a day, Trazodone 100 mg every evening, Paroxetine 20</p>	I 500	<p>I 500 See page 15 of 22</p> <p>ILS will insure review and approval of client medication changes (psychotropic medications) through the Human Rights Committee that meets on the 3<sup>rd</sup> Wednesday of every month following the medication review clinic with the Psychiatrist. Consent forms will be generated at each change of incident and the QMRP or Clinical Manager will contact family members, attorneys or guardians for consent the same day. In addition, the Human and Legal Rights Committee will meet the 3<sup>rd</sup> Wednesday of each month following the medication review clinic to review BSP and Psychotropic medications, or any other human rights issue as needed.</p>	12/18/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0206</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/05/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOULTIONS, INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7416 BLAIR ROAD, NW WASHINGTON, DC 20012</b>		
(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
I 500	Continued From page 16  mg and Zyprexa 5 mg every evening, among other medications and he received one-on-one staff support as part of his behavior management plan. Included in the ISP was a team recommendation to "maintain contact with the sister... she is available to provide pertinent information regarding his welfare..." Further review of the ISP revealed no evidence that the sister had been involved in the planning and/or review process (i.e. she had not attended meetings, there were no documented telephone calls or written communications, etc.).  Resident #4's records did not show evidence that his sister had received an explanation of his health condition(s) and/or given written consent for his treatment plan, including psychotropic medications...  On February 20, 2008, Resident #4's sister was interviewed by telephone... She verified that she had not attended ISP planning and development meetings. She confirmed that she was the designated healthcare decision-maker... Further interview revealed that ... no one from the facility had reviewed the resident's health... status with her. When asked if she was interested in knowing about her brother's medication regimen, she replied yes, and she would share the information with their siblings (who "all live out of town")... review of the April 2004 "Rights of Individuals" policy had revealed the following: a facility "designee will facilitate services relating to medical conditions and treatment being explained to the individual and/or his/her designee... this includes risks and benefits of medications and/or procedural interventions."  *****	I 500	I 500  The QMRP will review health plans and treatment plans with the individuals family members, guardians or attorneys at least quarterly, or in the event of any changes, immediate notification is mandated to include any explanation of risks and benefits. The Clinical Manager will review the current status of all individuals in the weekly Manager's meeting to insure implementation of this procedure.	12/18/08

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I 500	<p>Continued From page 17</p> <p>Previously, a January 10, 2008 Statement of Deficiencies report included the following:</p> <p>Resident #2 was observed during the evening medication pass on January 7, 2008 ... administered Chlorpromazine 150 mg by mouth. Interview with the Licensed Practical Nurse (LPN) ... revealed that Resident #2 was prescribed the medication for behavior management. Review of the physician's order sheet (POS) dated December 1, 2007 ... revealed that Resident #2 had diagnoses of Intermittent Explosive Disorder and Schizophrenia; Chronic Undifferentiated Type and was prescribed Chlorpromazine 150 mg by mouth twice a day and Lithium 150 mg every day for seven days. Lisinopril 5 mg. by mouth every day for behavior management. Interview with the Program Manager ... revealed that Resident #2's mother was very involved in his life but is not the resident's legal guardian. Review of Resident #2's, psychological assessment ... the resident did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Resident #2's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications.</p> <p>*****</p> <p>Previously, the Federal Deficiency Report dated February 1, 2007, indicated that there was no evidence that the &lt;facility's&gt; Human Rights Committee had ensured that informed consent had been obtained for the use of the behavior support plans, that included the use of psychotropic medications.</p>	I 500	<p>I 500 See page 17 of 22</p> <p>I 500</p> <p>ILS will insure review and approval of client medication changes (psychotropic medications) through the Human Rights Committee that meets on the 3<sup>rd</sup> Wednesday of every month following the medication review clinic with the Psychiatrist. Consent forms will be generated at each change of incident and the QMRP or Clinical Manager will contact family members, attorneys or guardians for consent the same day. In addition, the Human and Legal Rights Committee will meet the 3<sup>rd</sup> Wednesday of each month following the medication review clinic to review BSP and Psychotropic medications, or any other human rights issue as needed.</p>	12/18/08
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1500	<p>Continued From page 19</p> <p>Hepatitis B virus. In addition, Resident #1 reportedly bit Resident #4 on his right forearm on July 13, 2008. That bite reportedly broke the skin. These incidents had not been thoroughly investigated. In addition, Resident #1 reportedly was injected with Haldol while receiving services at a local hospital On June 3, 2008. The resident's Health Passport and physician's orders indicated that he was allergic to the medication. While the GHMRP reported the incident as a "medication error," the facility failed to investigate how and why the error occurred.</p> <p>(16) The GHMRP failed to ensure that Resident #4's record reflected documented evidence of a diptheria-tetanus booster shot that he received on December 18, 2006. On December 4, 2008, the booster was not reflected in the resident's medical chart. The following afternoon (December 5, 2008), the LPN presented a document that she had received just minutes earlier via fax transmittal from a hospital clinic, verifying the December 2006 vaccination. The LPN acknowledged that the facility had not maintained current immunology records for Resident #4.</p>	1500	<p>W 148 See page 10 of 27</p>	
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