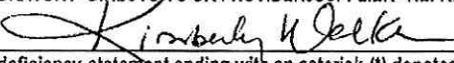


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2013
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 36TH STREET, SE WASHINGTON, DC 20024	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from December 18, 2013 through December 20, 2013. A sample of two clients was selected from a population of three men with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations, interviews with one client's guardian, direct support staff, nursing and administrative staff, as well as a review of clients' medical and habilitation records and the facility's administrative records, including incident reports and investigations.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Day Program Staff – DPS</p> <p>Health Regulation and Licensing Administration - HRLA Group Home for Individuals with Intellectual Disabilities - GHID Facility Coordinator - FC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN Vice President of Intellectual Disability Services - VPIDS</p>	W 000		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: VP of ID Services (X6) DATE: 1/10/14

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 153	<p>Continued From page 1</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review record, the facility failed to ensure that all allegations of neglect were reported to the Department of Health, HRLA, for two of three clients residing in the facility. (Clients #2 and #3)</p> <p>The findings include:</p> <p>I. on December 18, 2013, at 10:15 a.m., review of an investigation report dated March 22, 2013 revealed that the facility was informed on March 17, 2013 that an outside monitor made an allegation of neglect. According to the monitor, Client #2's nutrition records, including food intake documentation, did not consistently reflect implementation of the client's prescribed diet orders. Specifically, they alleged that staff did not ensure that Client #2 received three servings of nutrition supplement daily. In addition, the monitor alleged that on February 22, 2013, facility staff failed to encourage the client to alternate between food and drink during all meals. The internal investigation did not substantiate the allegation of neglect. However, additional staff in-service training was recommended regarding consistent documentation and to review mealtime protocols and the facility's policy on Neglect.</p> <p>Review of incidents that were reported to the</p>	W 153	<p>ILS updated the incident management policy on 11/1/13 and management staff was retrained on the proper reporting procedures per government regulation and policies (completed 1/2/14). In addition, ILS management staff received compliance training from DDS on 12/4/13 that covered the importance of incident reporting and making required notifications. The above mentioned trainings have helped ILS improve their internal reporting systems to ensure compliance. To prevent future occurrences and to protect the health and safety of all individuals, ILS will continue to train all staff on policies and regulations mandated by government agencies. Internal policies will continue to be implemented and updated as needed.</p>	

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W 153	<p>Continued From page 2</p> <p>State agency revealed no evidence that the allegation of neglect had been reported to HRLA</p> <p>II. On December 18, 2013, at 10:20 a.m., review of an investigation report dated March 22, 2013 revealed that on March 17, 2013, the outside monitor made another allegation of neglect. Specifically, they alleged that on February 22, 2013, facility staff did not consistently provide Client #3 foods that were finely chopped and failed to encourage the client to alternate between food and drink during all meals.</p> <p>The internal investigation did not substantiate the allegation of neglect. However, additional staff in-service training was recommended regarding consistent documentation and to review mealtime protocols and the facility's policy on Neglect. There was no evidence that this allegation of neglect was reported to the State agency.</p> <p>[Note: Attached to the two aforementioned investigation reports was documented evidence that facility staff received applicable in-service training on March 22, 2013.]</p> <p>When interviewed on December 18, 2013, at 3:45 p.m., the facility's incident management coordinator (IMC1) confirmed the two aforementioned incidents had not been reported to the State agency. However, she presented a revised Incident Management and Reporting Policy, dated November 1, 2013. The policies now reflected "IMC will make verbal notification and send a written synopsis of incident to DOH - call <DOH employee name and phone number> immediately for abuse and neglect. MC will follow up with written notification to the following sites by 5pm next business day" (including the</p>	W 153	<p>LS updated the incident management policy on 11/1/13 and management staff was retrained on the proper reporting procedures per government regulation and policies (completed 1/2/14).</p>	

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W 153	Continued From page 3 DOH website). MC1 assured this surveyor that any incidents fitting those parameters in the future would be reported in accordance with the policy.	W 153		
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's medical guardian and/or involved family members participated in the formulation of their habilitation planning, for one of two clients in the sample. (Client #2) The finding includes: Client #2's court-appointed guardian was interviewed by telephone on December 18, 2013, beginning at 2:53 p.m. According to the guardian, she only received "short notice" or interdisciplinary team (IDT) meetings and sometimes she did not receive any notification at all. She further stated that she would attend meetings "if I was told when they are having them. A couple days in advance isn't sufficient." She indicated it would be helpful to receive notifications "at least one week in advance." Continued interview with guardian revealed that she saw the client frequently, mostly through visits to his day program. The facility's QIDP had left the agency	W209	ILS management staff received an in-service (completed 1/7/14) on the internal ISP Policy that states notifications to all IDT members should be made via email at least 30 days prior to IDT meetings. To prevent future occurrences, ILS will ensure all management staff adhere to the ILS policy for all individuals, training will continue to be provided as needed.	

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W 209	Continued From page 4 approximately two weeks prior to this survey. On December 20, 2013, beginning at 3:38 p.m., interview with the facility manager (FC1) and the vice president of intellectual disability services (VPIDS1) revealed that QIDPs typically prepared an annual calendar of clients' IDT meetings for the coming year. In addition, they believed the QIDP sent notifications via email to all team members, including guardians. They further indicated that said practices were not reflected in the agency's written policies and procedures. FC1 reviewed the emails that he had received and found that a notification email sent by the former QIDP on June 17, 2013, for Client #2's ISP meeting scheduled for June 28, 2013, did not include the guardian's email address on the distribution list. VPIDS1 looked in Client #2's records and confirmed there was no documentation showing the guardian had been notified of meetings. She also confirmed the guardian had not signed the ISP meeting attendance sheet on June 28, 2013.	W 209		
W 472	At the time of the survey, the facility failed to show evidence that participation by Client #2's guardian was unobtainable. 483.480(b)(2)(i) MEAL SERVICES Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food portions were served in the appropriate quantity, for one of two clients in the sample. (Client #2) The finding includes:	W 472	IIS conducted staff training on 1/3/14. Please see information below.	

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W 472	<p>Continued from page 5</p> <p>On December 19, 2013, at 11:40 a.m., observation of Client #1's and Client #2's lunches revealed that they brought lunches that were prepared at home. Each client's lunch consisted of a ham and cheese sandwich, an individual serving of fruit juice and a cup of yogurt. There was no vegetable observed. A day program direct support staff (DPS1) who said she had worked with the two clients since September 2013 stated that she rarely saw them bring any vegetable. She recalled their having brought coleslaw approximately three weeks prior to the survey (no vegetables observed since).</p> <p>On December 19, 2013, at 9:30 a.m., review of Client #1's diet orders revealed he was prescribed an 1800 calorie, low fat, low cholesterol, high fiber, regular texture diet. Client #2 was prescribed a 2000-2100 calorie, high fiber, chopped texture diet with 8 ounces of ice cream three times daily and three 8-ounce servings of Boost Plus daily. According to the menu that was presented by the facility coordinator (FC1) on December 19, 2013, at 1:15 p.m., Clients #1 and #2's lunches should have included carrot and celery sticks and a serving of 2% milk with the sandwich and a fruit cup on that day. Review of recent lunch menus revealed that carrot and raisin salad should have gone with the clients on Tuesday of that week and on Monday of the week prior to this survey. Their lunches on the previous Thursday (December 12, 2013) were to include carrot and celery sticks.</p> <p>A direct support staff (DSP1) was interviewed in the home on December 20, 2013, beginning at 8:20 a.m. He said he had prepared lunch for Clients #1 and #2 on the day before. He</p>	W 472	<p>ILS management in-service (completed 1/3/14) all DSP's on the following:</p> <ul style="list-style-type: none"> • lunch preparation based on menu and protocol • packing lunches with items or appropriate substitutions based on the menu • reiterated that lunches should be packed in an integrated cooling system for proper transport to day programs • vegetables, milk, salads, etc. being included per menu. <p>In effort to prevent future occurrences, ILS management will schedule for the Nurse, Nutritionist, and Speech Pathologist to conduct and in-service with all DSP's regarding meal planning, menus and substitutions by 1/20/14. In addition, a meeting will be held with ILS designated person for food shopping to ensure items are being purchased according to the menu by 1/20/14.</p>		

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W 472	<p>Continued From page 6</p> <p>confirmed that he substituted ham and cheese for the tuna sandwich. He said he packed the fruit juice as a substitute for milk, explaining that he worried the milk would not stay cold enough (for safety). The yogurt cup reportedly was a substitute for the fruit cup. He acknowledged that he had not included carrot and celery sticks (or appropriate substitute) in the previous day's lunches, in accordance with the menus.</p> <p>On December 19, 2013, beginning at 1:27 p.m. • review of staff in-service training records revealed; staff had been trained on diets and nutrition on March 22, 2013, May 21, 2013 and October 2, 2013. Lunch observations on December 19, 2013, however, revealed that staff did not consistently present foods in accordance with the prepared menus.</p>	W472		

Health Regulation & Licensing Administration

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WASHINGTON, DC 20024

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1000	INITIAL COMMENTS A licensure survey was conducted from December 18, 2013 through December 20, 2013. A sample of two residents was selected from a population of three men with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process. The findings of the survey were based on observations, interviews with one residents guardian, direct support staff, nursing and administrative staff, as well as a review of residents' medical and habilitation records and the facility's administrative records, including incident reports and investigations. Note: The below are abbreviations that may appear throughout the body of this report. Day Program Staff - DPS Direct Support Professional - DSP Health Regulation and Licensing Administration - HRLA Group Home for Individuals with Intellectual Disabilities - GHIID Facility Coordinator - FC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN Vice President of Intellectual Disability Services - VPIDS	1 000		
1040	3502.1 MEAL SERVICE IN DINING AREAS 1 Each GHMRP shall provide each resident with a	1040		

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

Kimberly Walker

TITLE

VP of ID Services

(X5) DATE

1/10/14

Health Regulation & Licensing Administration

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1040	<p>Continued From page 1</p> <p>nourishing, well-balanced diet.</p> <p>This Statute Is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure each resident received well-balanced, nutritious meals, for two of two residents in the sample. (Residents #1 and #2)</p> <p>The finding includes:</p> <p>On December 19, 2013, at 11:40 a.m., observation of Resident #1's and Resident #2's lunches revealed that they brought lunches that were prepared at home. Each resident's lunch consisted of a ham and cheese sandwich, an individual serving of fruit juice and a cup of yogurt. There was no vegetable observed. A day program direct support staff (DPS1) who said she had worked with the two residents since September 2013 stated that she rarely saw them bring any vegetable. She recalled their having brought coleslaw approximately three weeks prior to the survey (no vegetables observed since).</p> <p>On December 19, 2013, at 9:30 a.m., review of Resident #1's diet orders revealed he was prescribed an 1800 calorie, low fat, low cholesterol, high fiber, regular texture diet. Resident #2 was prescribed a 2000-2100 calorie, high fiber, chopped texture diet with 8 ounces of ice cream three times daily and three 8-ounce servings of Boost Plus daily. According to the menu that was presented by the facility coordinator (FC1) on December 19, 2013, ;;it 1:15 p.m., Residents #1 and #2's lunches should have included carrot and celery sticks and a serving of 2% milk with the sandwich and a fruit cup on that</p>	1040	<p>ILS in-serviced all staff on 1/3/14 (see attached). In effort to prevent future occurrences, ILS management will schedule for the Nurse, Nutritionist, and Speech Pathologist to conduct and in-service with all DSP's regarding meal planning, following menus and substitutions by 1/20/14.</p> <p>In addition, a meeting will be held with ILS designated person for food shopping to ensure items are being purchased according to the menu by 1/20/14.</p>	

Health Regulation & Licensing Administration

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1040	<p>Continued From page 2</p> <p>day. Review of recent lunch menus revealed that carrot and raisin salad should have gone with the residents on Tuesday of that week and on Monday of the week prior to this survey. Their lunches on the previous Thursday (December 12, 2013) were to include carrot and celery sticks.</p> <p>A direct support staff (DSP1) was interviewed in the home on December 20, 2013, beginning at 8:20 a.m. He said he had prepared lunch for Residents #1 and #2 on the day before. He confirmed that he substituted ham and cheese for the tuna sandwich. He said he packed the fruit juice as a substitute for milk, explaining that he worried the milk would not stay cold enough (for safety). The yogurt cup reportedly was a substitute for the fruit cup. He acknowledged that he had not included carrot and celery sticks (or appropriate substitute) in the previous day's lunches, in accordance with the menus.</p> <p>On December 19, 2013, beginning at 1:27 p.m., review of staff in-service training records revealed staff had been trained on diets and nutrition on March 22, 2013, May 21, 2013 and October 2, 2013. Lunch observations on December 19, 2013, however, revealed that staff did not consistently present foods in accordance with the prepared menus.</p> <p>At the time of the survey, GHID staff failed to ensure that Residents #1 and #2 received the appropriate amount of food for lunch.</p>	1040	<p>ILS in-serviced all staff on 1/3/14. In effort to prevent future occurrences, ILS management will schedule for the Nurse, Nutritionist, and Speech Pathologist to conduct and in-service with all DSP's regarding meal planning, menus and substitutions by 1/20/14. In addition, a meeting will be held with ILS designated person for food shopping to ensure items are being purchased according to the menu by 1/20/14.</p>	
1378	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other</p>	1379		

Health Regulation & Licensing Administration

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1379	<p>Continued From page 3</p> <p>unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, DOH/HRLA, for two of the three residents of the facility. (Residents #2 and #3)</p> <p>The findings include:</p> <p>I. The GHIID failed to notify DOH/HRLA of all significant medical incidents, as follows:</p> <p>On December 18, 2013, at 10:09 a.m., review of an incident investigation report (dated July 15, 2013) revealed that Resident #2 was taken to a hospital emergency room (ER) to assess a swollen right hand shortly after his arrival at the day program on July 10, 2013. There was no evidence the ER visit was reported to HRLA.</p> <p>Interview with the facility's incident management coordinator (IMC1) by telephone on December 18, 2013, at 10:50 a.m. confirmed that Resident #2 was taken to the ER on July 10, 2013. She stated that the day program was responsible for notifications and ILS was responsible for ensuring</p>	1379	<p>ILS updated the incident management policy on 11/1/13 and management staff was retrained on the proper reporting procedures per government regulation and policies (completed 1/2/14). In addition, ILS management staff received compliance training from DDS on 12/4/13 that covered the importance of incident reporting and making required notifications. The above mentioned trainings have helped ILS improve their internal reporting systems to ensure compliance.</p> <p>To prevent future occurrences and to protect the health and safety of all individuals, ILS will continue to train all staff on policies and regulations mandated by government agencies. Internal policies will continue to be implemented and updated as needed.</p>	

Health Regulation & Licensing Administration

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1379	<p>Continued From page 4</p> <p>that the day program achieved the notifications. A moment later, she reported having boked on a central database and she could find no evidence that the day program had notified HRLA of that incident.</p> <p>II. The GHID failed to notify DOH/HRLA of all allegations of neglect, as follows:</p> <p>A. On December 18, 2013, at 10:15 a.m., review of an investigation report dated March 22, 2013 revealed that the facility was informed on March 17, 2013 that an outside monitor made an allegation of neglect. According to the monitor, Resident #2's nutrition records, including food intake documentation, did not consistently reflect implementation of the client's prescribed diet orders. Specifically, they alleged that staff did not ensure that Resident #2 received three servings of ice cream daily and three portions of Boost Plus nutrition supplement daily. In addition, the monitor alleged that on February 22, 2013, facility staff failed to encourage the client to alternate between food and drink during all meals. The internal investigation did not substantiate the allegation of neglect. However, additional staff in-service training was recommended regarding consistent documentation and to review mealtime protocols and the facility's policy on Neglect.</p> <p>Review of incidents that were reported to the State agency revealed no evidence that the allegation of neglect had been reported to HRLA.</p> <p>B. On December 18, 2013, at 10:20 a.m., review of an investigation report dated March 22, 2013 revealed that on March 17, 2013, the outside monitor made another allegation of neglect. Specifically, they alleged that on February 22, 2013, facility staff did not consistently provide</p>	1 379		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0198	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING	(X3) DATE SURVEY COMPLETED 12/20/2013
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I379	<p>Continued From page 5</p> <p>Resident #3 foods that were finely chopped and failed to encourage the client to alternate between food and drink during all meals.</p> <p>The internal investigation did not substantiate the allegation of neglect. However, additional staff in-service training was recommended regarding consistent documentation and to review mealtime protocols and the facility's policy on Neglect. There was no evidence that this incident was reported to the State agency.</p> <p>[Note: Attached to the two aforementioned investigation reports was documented evidence that facility staff received applicable in-service training on March 22, 2013.]</p> <p>When interviewed on December 18, 2013, at 3:45 p.m., IMC1 confirmed the two aforementioned incidents had not been reported to DOH/HRLA. She then presented the facility's Incident management and Reporting Process policy. The policy had been revised effective November 1, 2013. The policies now reflected "IMC will make verbal notification and send a written synopsis of incident to DOH - call <DOH employee name and phone number> immediately for abuse and neglect and incidents affecting the health, safety and well being of the individual... MC will follow up with written notification to the following sites by 5pm next business day" (including the DOH website). IMC1 assured this surveyor that any incidents fitting those parameters in the future would be reported in accordance with the policy.</p>	1 379	<p>ILS updated the incident management policy on 11/1/13 and management staff was retrained on the proper reporting procedures per government regulation and policies (completed 1/2/14). In addition, ILS management staff received compliance training from DDS on 12/4/13 that covered the importance of incident reporting and making required notifications. The above mentioned trainings have helped ILS improve their internal reporting systems to ensure compliance.</p> <p>To prevent future occurrences and to protect the health and safety of all individuals, ILS will continue to train all staff on policies and regulations mandated by government agencies. Internal policies will continue to be implemented and updated as needed.</p>	