

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

PRINTED: 11/30/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2011
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7428 8TH STREET NW WASHINGTON, DC 20012	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An initial certification survey was conducted at your facility from November 21, 2011 through November 22, 2011, utilizing the full survey process. A sampling of two clients was selected from a residential population of two males with intellectual disabilities. The findings of the survey were based on observations at the group home, one day program, interviews with staff, and the review of clinical and administrative records, including incident reports.	W 000	<p><i>Received 12/9/11</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the six clients in the facility. (Client #2) The finding includes: On November 21, 2011, at 4:28 p.m., the licensed practical nurse (LPN) and the certified nurse assistant (CNA) were observed changing Client #2's clothes. At 5:33 p.m., the CNA and the LPN changed Client #2's adult protective undergarment (APU). During this time Client #1 was sitting in his wheelchair facing Client #2's open bedroom door. Further observation revealed the CNA was talking to Client #1 as she changed Client #2's APU with the LPN.	W 130		The privacy for each individual will be respected at all times. Staff will be inserviced on client privacy and rights

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE EXECUTIVE DIRECTOR (X6) DATE 12/9/11

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 130	Continued From page 1 Interview with the CNA at 5:41 p.m., revealed that she wheeled Client #1 in front of Client #2's bedroom because she did not want to leave him alone while she attended to Client #2. There was no evidence that staff ensured privacy during Client #2's personal care.	W 130		
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 observation, interview and record review, the facility failed to ensure general and preventative care services, for two of two clients in the sample. (Clients #1 and #2) The findings include: 1. Observation on November 21, 2011, at approximately 6:00 p.m., revealed Client #2's gastrostomy tube was flushed with three hundred and eighty milliliters (380 ml) of water after medication administration. Interview with LPN #2 on November 21, 2011, at approximately 6:10 p.m., revealed Client #2's gastrostomy tube was to be flushed twice a day (6:00 a.m. and 6:00 p.m.) with 380 ml of water. Review of Client #2's POS dated November 1, 2011, on November 21, 2011, at approximately 6:25 p.m., confirmed the gastrostomy tube was to be flushed at 6:00 a.m. and 6:00 p.m., with 380	W 322	PCP clarification regarding the flushes of water obtained. Recommendations from PCP will be implemented accordingly. All recommendations from all consults will be reviewed by the LPN upon receipt and RN weekly to ensure no ambiguity.	12/7/11 12/15/11

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W 322	<p>Continued From page 2 ml of water.</p> <p>Review of the Client #2's gastroenterologist consult dated September 13, 2011 on November 22, 2011, at approximately 2:00 p.m., revealed the following recommendation "after each feeding, wash tube with seventy-five cc of water". Further review revealed the PCP was notified and reviewed in writing the gastroenterologist consult.</p> <p>There was no documented evidence the PCP specifically addressed the recommendations of the gastroenterologist.</p> <p>2. Observation of the medication pass on November 21, 2011, at approximately 5:50 p.m., revealed Client #2 was administered Captopril 50 mg for hypertension via gastrostomy tube by LPN #2.</p> <p>During a face to face interview with LPN #2 on November 21, 2011, at approximately 6:30 p.m., revealed Client #2 was also prescribed Phenobarbital 20 mg/5 ml mg for seizure management every day.</p> <p>Interview with LPN #1 on November 22, 2011, at approximately 2:05 p.m., revealed Client #2 did not have ophthalmology, neurology, pulmonary or cardiology consults in the medical record. Further interview revealed Client #2's legal guardian did not want the client to have the aforementioned diagnostic consultations performed.</p> <p>Review of Client #2's " Statement of Variance" dated March 8, 2011, on November 22, 2011, at approximately 2:10 p.m., signed by the legal guardian stated they were aware of the potential</p>	W 322	<p>PCP provided needed referral/guidance for Cardiology and Ophthalmology appointments. Cardiology appointment scheduled as recommended. 12/7/11</p> <p>PCP will determine needed schedule for labs. Recommendations from PCP will be implemented accordingly. LPN will ensure implementation of a regular lab schedule as recommended. 12/7/11</p> <p>Any appointment and/or lab work that is refused will result in a variance form signed by the guardian of DB and filed in medical record. 12/10/11</p> <p>Appointment scheduled for DB for Pulmonary. All recommendation will be followed accordingly. 2/3/12</p>

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W 322	<p>Continued From page 3</p> <p>risks associated with deviating from the recommendations of professional member of the Interdisciplinary Team, however they did not want Client #2 to have ENT (EARS, NOSE and Throat), lab work, podiatry, cardiology or ophthalmology services performed.</p> <p>Review of Client #2's POS dated November 1, 2011, on November 22, 2011, at approximately 10:50 a.m., confirmed Client #2 was prescribed the aforementioned medications.</p> <p>Review of Client #2's medical evaluation form dated October 14, 2011, on November 22, 2011, at approximately 2:15 p.m., revealed the client's diagnoses included seizure disorder and hypertension. Further recommendation revealed Phenobarbital 20 mg/5 ml mg was to be continued.</p> <p>Review of a nursing progress note dated November 22, 2011, revealed that on November 19, 2011, Client #2's anesthesiologist refused to perform scaling and sealing under sedation because the client did not have a neurology or pulmonary consult in the medical record.</p> <p>There was no documented evidence the PCP ordered ophthalmology, neurology, pulmonary and cardiology consults for the client or addressed the reasons why the consults would be contraindicated for the client.</p> <p>3. Observation of the gastric tube feeding on November 21, 2011, at approximately 6:00 p.m., revealed Client #2 was positioned in bed at a forty-five degree angle as LPN #2 administered five (5) cans of Ensure (Immune Health), eight (8)</p>	W 322	<p>ILS will ensure maintenance of all medical appointments and needed follow up. LPN will be inserviced on maintaining medical appointment schedule.</p> <p>Appointment scheduled for DB for Neurology. All recommendations will be followed accordingly.</p> <p>ILS will ensure maintenance of all medical appointments and needed follow up. LPN will be inserviced on maintaining medical appointment schedule.</p> <p>Nutritionist revised nutritional report to reflect the correct caloric amount and amend the number of cans (5) to provide for g-tube feeding. All recommendations to be followed according to consult. ILS will ensure all recommendations from consults will be reviewed by the LPN and QDDP upon receipt to ensure no ambiguity.</p>	<p>12/15/11</p> <p>2/1/12</p> <p>12/15/11</p> <p>12/12/11</p>

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W 322	Continued From page 4 fluid ounces (237 ml) via an Enteral Gastric Pressure Relief System attached to a Kangaroo Pump to run at one hundred and ten (110) milliliters an hour. Interview with Registered Nurse (RN), LPN #1 and #2 on November 22, 2011, at approximately 3:15 p.m., revealed Client #2 was to be positioned at a forty -five (45) to ninety (90) degree angle when receiving a gastrostomy tube feeding. Review of the physical therapy (PT) note dated October 17, 2011, on November 22, 2011, at approximately 3:18 p.m. revealed the nurse reported that Client #2 should be positioned at a forty-five degrees to prevent aspiration. Further review of the PT note revealed "continue with position per physician orders". Review of the speech language evaluation dated March 3 and March 7, 2011, on November 22, 2011, at approximately 3:20 p.m. revealed no recommendation on how to position Client #2 during the gastrostomy tube feeding. Review of the nutritional consult dated June 28, 2011, and quarterly nutritional assessment dated September 3, 2011, on November 22, 2011, at approximately 3:20 p.m. did not reveal a recommendation on how to position Client #2 during the gastrostomy tube feeding. Review of Client #2's POS dated November 1, 2011, on November 22, 2011, at approximately 3:25 p.m., revealed the POS did not include an order on how to position Client #2 during the gastrostomy tube feeding.	W 322	PCP for DB completed an order for feeding positions stating feeding positions to be at 45 degrees All staff will be inserviced by RN on correct feeding positions. Nutritionist, Physical Therapist and Speech Therapist will be notified of feeding positions per the PCP. Assessments revised accordingly.	12/7/11 12/15/11 12/23/11

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W 322	Continued From page 5 There was no evidence the PCP wrote an order on how to position Client #2 during the gastrostomy tube feeding.	W 322		

Health Regulation & Licensing Administration

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1000	INITIAL COMMENTS An licensure survey was conducted at your facility from November 21, 2011 through November 22, 2011. A sampling of two residents was selected from a population of two males with intellectual disabilities. The findings of the survey were based on observations at the group home, one day program, interviews with staff, and the review of clinical and administrative records, including incident reports.	1000		
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and inspection of the environment, the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of its residents. The finding includes: On November 22, 2011, at 4:00 p.m., while conducting an environmental inspection with the house manager, the lint tray in the dryer was observed with an heavy accumulation of lint. The house manager acknowledged the finding and indicated that she will re-train the staff.	1090	Staff inserviced on ensuring the lint tray of the dryer is emptied. ILS will post reminder by dryer for lint removal	12/2/11 12/15/11

Health Regulation & Licensing Administration

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

STATE FORM

TITLE

(X8) DATE

EXECUTIVE DIRECTOR

12/9/11

6899

T9G911

If continuation sheet 1 of 5

Health Regulation & Licensing Administration

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I 401	Continued From page 1	I 401		
I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included treatment services, and services designed to prevent deterioration or further loss of functioning by the resident for two of four residents in the facility. (Resident # 1 and #2)</p> <p>The findings include:</p> <p>1. Observation on November 21, 2011 at approximately 8:00 pm revealed Resident #2's gastrostomy tube was flushed with three hundred and eighty milliliters (380 ml) of water after medication administration.</p> <p>Interview with LPN #2 on November 21, 2011, at approximately 6:10 pm revealed Resident #2's gastrostomy tube was to be flushed twice a day (6:00 am and 6:00pm) with 380 ml of water.</p> <p>Review of Resident #2's POS dated November 1, 2011, on November 21, 2011, at approximately 6:25 pm confirmed the gastrostomy tube was to be flushed at 6:00 am and 6:00 pm with 380 ml of water.</p> <p>Review of the Resident #2's gastroenterologist</p>	I 401		
			See W322	

Health Regulation & Licensing Administration

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I 401	<p>Continued From page 2</p> <p>consult dated September 13, 2011 on November 22, 2008 at approximately 2:00 pm , revealed the following recommendation "after each feeding wash tube with seventy-five cc of water". Further review revealed the PCP was notified and reviewed in writing the gastroenterologist consult.</p> <p>There was no documented evidence the PCP specifically addressed the recommendations of the gastroenterologist.</p> <p>2. Interview with LPN #2 on November 21, 2011, at approximately 6:30 pm revealed Resident #2 was prescribed Phenobarbital 20 mg/5 ml mg for seizure management every day.</p> <p>During a face to face interview with LPN #1 on November 22, 2011 @ on November 22, 2011, at approximately 2:15 pm revealed Resident #2 did not have an ophthalmology, neurology, pulmonary and cardiology consult in the medical record. Further interview revealed Resident #2's legal guardian did not want the resident to have the aforementioned diagnostic consultations performed.</p> <p>Review of Resident #2's POS dated November 1, 2011, on November 22, 2011, at approximately 10:50 am, confirmed Resident #2 was prescribed Phenobarbital 20 mg/5 ml mg for seizure management every day.</p> <p>Review of Resident #2's medical evaluation form dated October 14, 2011, on November 22, 2011, at approximately 2:15 pm revealed the client's diagnoses included seizure disorder and hypertension. Further recommendation revealed Phenobarbital 20 mg/5 ml mg was to be continued.</p>	I 401	W322	

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I 401	Continued From page 3 Review of a nursing progress note dated November 22, 2011, revealed on November 19, 2011, Resident #2's anesthesiologist refused to perform a dental procedure under sedation because the resident did not have a neurology or pulmonary consult in the medical record. There was no documented evidence the PCP ordered ophthalmology, neurology, pulmonary and cardiology consults for the client or addressed the reasons why the consults would be contraindicated for the resident. 3. Observation of the gastric tube feeding on November 21, 2011, at approximately 6:00 pm revealed Client #2 was positioned in bed at a forty-five degree angle as LPN #2 administered five (5) cans of Ensure (Immune Health), eight (8) fluid ounces (237 ml) via an Enteral Gastric Pressure Relief System attached to a Kangaroo Pump to run at one hundred and ten (110) milliliters an hour. Interview with Registered Nurse (RN), LPN #1 and #2 on November 22, 2011, at approximately 3:15 pm revealed Resident#2 was to be positioned at a forty-five (45) to ninety (90) degree angle when receiving a gastrostomy tube feeding. Review of the speech language evaluation dated March 3 and March 7, 2011, on November 22, 2011, at approximately 3:18 p.m. revealed no recommendation on how to position Resident #2 during the gastrostomy tube feeding. Review of the nutritional consult dated June 28, 2011 and quarterly nutritional assessment dated September 3, 2011, on November 22, 2011, at approximately 3:20 p.m. did not reveal a	I 401	3. PCP for DB completed an order for feeding positions stating feeding positions to be at 45 degrees All staff will be inserviced by RN on correct feeding positions. Nutritionist, Physical Therapist and Speech Therapist will be notified of feeding positions per the PCP. Assessments revised accordingly.	12/7/11 12/15/11 12/23/11

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I 401	Continued From page 4 recommendation on how to position Resident #2 during the gastrostomy tube feeding. Review of the physical therapy note dated October 17, 2011, on November 22, 2011, at approximately 3:25 pm revealed Resident #2 was revealed "nurse reported [Resident #2] should be positioned at a forty-five degrees to prevent aspiration. Further review revealed "continue with position per physician orders". Review of Resident #2's POS dated November 1, 2011, on November 22, 2011, at approximately 3:27 pm, revealed the POS did not include an order on how to position Resident #2 during the gastrostomy tube feeding. There was no evidence the PCP wrote an order on how to position Resident #2 during the gastrostomy tube feeding.	I 401			