

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD120089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/27/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOLUTIONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3043 BLADENSBURG ROAD, NE WASHINGTON, DC 20018</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 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from March 26, 2013, through March 27, 2013. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home, interviews with residents, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000	<p><i>Received 4/29/13</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
I 206	<p><b>3509.6 PERSONNEL POLICIES</b></p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure that all direct support staff had current health certificates for 1 of 17 direct support staff (Direct support staff #14).</p> <p>The finding includes:  On March 26, 2013, beginning at 2:40 p.m.,</p>	I 206		

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

TITLE *Director of QA* (X8) DATE *4/29/13*

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I 206	Continued From page 1 review of the personnel records for all employees, revealed the following:  There was no evidence of a health inventory/certificate for direct support Staff #14.  The house manager (HM) during the exit review acknowledged the findings and indicated follow-up with the human resources director will be implemented.	I 206		
I 422	<b>3521.3 HABILITATION AND TRAINING</b>  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.  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 that residents were provided one to one supervision in accordance with his individual support plan (ISP) for one of the three residents included in the sample. (Resident #1)  The findings include:  The facility failed to ensure Resident #1 was provided with one to one supervision in accordance with his individual support plan (ISP) as evidenced below:  On March 26, 2013, beginning at 9:57 a.m., an entrance interview was conducted with the qualified intellectual disabilities professional (QIDP). The interview with the QIDP revealed Resident #1 had a behavioral support plan (BSP) to address his maladaptive behaviors of physical aggression and inappropriate affection. Review	I 422	<b>I206</b> Innovative Life Solutions will ensure all personnel records are audited.  ILS has implemented imanager an IT system to track HR Personnel records for expirations on a monthly basis, and create alerts to all pertaining parties 30 days prior to all expirations.  See attachment #1  <b>I 422</b> ILS has increased the staffing ratio for that facility in order to provide 1:1 staffing supervision services for Resident #1 as required. ILS will continue to provide 1:1 services after prior authorization it approved.  Staff in-service was completed on BSP and staff supervision on 4/22/13 by the Psychologist. See attachment #2	

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I 422	<p>Continued From page 2</p> <p>of the BSP dated October 19, 2012, on March 27, 2013, at 11:00 a.m. revealed the behavioral specialist made a recommendation for Resident #1 to receive one to one supervision. Further review of the BSP revealed a section entitled "Current Behavioral Concerns and Functional Analysis," that indicated incidents of physical aggression were noted to last up to 30 minutes. Also the document indicated that "there are times when the resident may be attempting to gain someone's attention by grasping their arms or clothing, which may be misinterpreted as aggression." At other times when [resident's name] would grab an individual quite forcefully and the individual would be inadvertently scratched as they are attempting to extricate themselves."</p> <p>The QIDP revealed on March 27, 2013, beginning at 11:15 a.m., that the facility was not providing Resident #1 with one to one supervision. Further interview with the QIDP revealed the resident's interdisciplinary team had discussed his need for one to one supervision during his 30-day review which was held on October 15, 2012. Continued discussion with the QIDP, revealed the team agreed to the recommendation for one to one supervision to be provided for Resident #1 during waking hours. According to the QIDP, the request for one to one services for Resident #1 was submitted to the Department on Disability Services' (DDS), service coordinator at the time of the 30-day review.</p> <p>Review of Resident #1's behavior data on March 27, 2013, at 11:41 a.m. revealed Antecedent, Behavior, Consequence (ABC) forms recorded by staff for the period January 3, 2013 through March 23, 2013. Further review of the ABC data revealed the resident displayed sixteen (16)</p>	I 422		

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I 422	Continued From page 3 incidents of physical aggression.  On March 27, 2013, observations beginning 2:24 p.m. revealed Resident #1 had arrived home from his day program. After staff assistance with washing his hands, the resident was observed seated at the facility's dining room table for his afternoon snack. At 2:30 p.m., the resident was observed to independently take his saucer to the kitchen after finishing his snack. Upon the resident's return from the kitchen, he was observed to get a box of Lego 's from the facility's floor and sat with them at the dining area table. It should be noted that the resident was not observed to be provided with one to one supervision throughout the surveying process. Interview with the direct care staff (DCS) on March 26, 2013, at 4:31 p.m. revealed that he accompanied Resident #1 on an outing with his day program due to the resident's behaviors. Further interview with the DCS revealed the resident will grab anyone. The DCS also revealed when the resident is about to exhibit a behavior, there is usually no antecedent. Continued interview revealed whenever Resident #1 grabs someone, it is difficult to separate him from that individual. At 4:55 p.m., Resident #1 was observed to continue putting Lego 's together while one staff was observed in the kitchen preparing the resident's dinner. Two other direct care staff was on duty, however, interview and observations revealed one to one support was not provided for Resident #1. At the time of the survey, the facility failed to ensure that Resident #1 was provided one to one supervision in accordance with his behavioral support plan (BSP).	I 422		