

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

PRINTED: 08/14/2013  
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>07/26/2013</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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W 249	<p>Continued From page 44</p> <p>that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Client #1 and verbally prompted the client to calm down but was unsuccessful.</p> <p>Interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Client #2. DSP #3 revealed that he was positioned in the living room with Client #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Client #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Client #1's 1:1 support staff) jumped up and moved away from Client #1. DSP #3 verbally prompted the [client] to calm down and asked, "Are you ok?" DSP #3 then stated that Client #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the client and placed the client's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his client, Client #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Client #1 some water. DSP #3 went back over to Client #1 and the client used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Client #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Client #1 hit himself a few more time. DSP #3 stated that he walked over to Client #1 and stated, "That's enough" in a firm voice.</p> <p>On July 10, 2013, beginning at approximately 5:10 p.m., review of Client #1's BSP dated April 13, 2013, revealed Client #1 had maladaptive</p>	W 249			

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W 249	<p>Continued From page 45</p> <p>behaviors that included physical aggression, SIB (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision is needed for behavior support implementation, and to ensure the safety of the client, given the high level of risk of several of his target behaviors. Continued review of the BSP revealed that if Client #1 engaged in SIB, staff should implement the following proactive strategies:</p> <p>a. Whenever possible, he [client] should be redirected before he actually attempts to engage him in this behavior.</p> <p>b. As soon as it is feasible, staff should attempt to identify the stimulus for this behavior. This includes if Client #1 is only beginning to become agitated. If a stimulus can be ID, staff should attempt to address this as soon as possible.</p> <p>c. If Client #1 begins to engage in SIB, staff should first attempt to verbally redirect him away from this and toward an activity. For example, staff may offer to take the client for a walk, offer an activity using his hands, assist with the laundry, offer choices, etc. Staff may say in a calm but firm voice, "Please stop (state behavior)!"</p> <p>d. If the client does not respond to verbal redirection and continues to engage in SIB, staff should refer to the crisis intervention plan.</p> <p>Review of the crisis intervention plan revealed that if Client #1 became agitated and began to present a danger to himself or others, staff may use the least restrictive, least intrusive strategy possible. Implement a program-approved by the</p>	W 249		

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W 249	<p>Continued From page 46 facility. For example, staff could use supportive physical techniques, one or two person escort and/or any relevant blocks or releases to assist Client #1.</p> <p>At the time of the investigation, the facility failed to ensure Client #1's BSP was implemented as outlined.</p> <p>2. Direct Support Professional (DSP) #8 and DSP #4 failed to ensure Clients #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following:</p> <p>a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Client #2 as his one to one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all clients were in bed asleep. At approximately 10:30 p.m., DSP #8 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8 stated that while walking back upstairs, he heard a thump/shuffle that came from Client #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the client's room. As he stepped inside the bedroom, he indicated he witnessed Client #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4</p>	W 249		

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W 249	<p>Continued From page 47</p> <p>came running behind him and after observing the client's injury he said, "I'm going to get the first aid kit." Client #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911 emergency services. As a result of the injury, Client #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Client #2 at all times in accordance with the BSP.</p> <p>On July 11, 2013, at approximately 5:00 p.m., review of Client #2's BSP dated April 13, 2013, revealed that although the client was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Client #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the client. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours.</p> <p>b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Client #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Client #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated that DSP #8 informed him that he was going downstairs to work on the laundry and to get the mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the client went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained</p>	W 249		

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W 249	Continued From page 48 outside of Client #1's bedroom and checked on him every 30 minutes.  On July 10, 2013, beginning at approximately 5:10 p.m., review of the Client #1's BSP dated April 13, 2013, revealed Client #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the client, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours.  Note: It should be noted that on July 18, 2013, beginning at 10:50 a.m., interview with the former residential counselor (RC) revealed that it was her expectation that 1:1 staff were to remain within arm's length of their assigned clients throughout their shift. A telephone interview conducted with the former qualified intellectual disabilities professional on July 19, 2013, beginning at 1:33 p.m., verified the former RC's interview.	W 249		
W 318	483.460 HEALTH CARE SERVICES  The facility must ensure that specific health care services requirements are met.  This CONDITION is not met as evidenced by: Based on interviews and record verification, the facility failed to provide preventive health care	W 318	W 318/W 322  The agency has developed a system to ensure that all individuals receive appropriate and timely medical attention and oversight.  <ul style="list-style-type: none"> <li>The assigned caseload for the medication administration nursing staff has been reduced.</li> <li>All nursing staff have received an in-service on telephone triaging – also received a text book – telephone triage</li> <li>All nurses meet with the DON, for weekly training and submission of a weekly report on the status of the individuals in their case load.</li> <li>The DON submits a weekly health status report to the senior management team.</li> </ul>	

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W 318	Continued From page 49 services to meet one client's assessed needs [See W322] and failed to ensure skilled nursing services, to ensure one client's health and safety [See W331].	W 318	<ul style="list-style-type: none"> <li>The bowel movement management process has been revised to increase nurse oversight and accountability at the residential and day program locations.</li> <li>The PRN laxative process and procedure has been developed for individuals receiving laxatives and for those individuals who need to have their BMs monitored on a daily basis</li> <li>The medication nurse involved with this situation has been placed on administrative leave pending the closure of this investigation</li> <li>A weekly system of RN Supervisor oversight of all MARs to ensure accuracy in medication administration.</li> <li>All the nursing and direct support staff have been in-serviced on the following:                             <ul style="list-style-type: none"> <li>Medication administration policy and procedure – address physician's signature for verbal orders, PRN orders, MARs – documentation of PRN orders and efficacy of PRN medication</li> <li>Emergency medical procedure, transportation and notification process</li> <li>'PRN laxative' process and procedure and documentation</li> <li>Daily BM monitoring procedure</li> <li>Medication nurse schedule</li> <li>1:1 job description – function during emergencies</li> </ul> </li> </ul>	8/25/13	
W 322	<p>The effects of these systemic practices resulted in the demonstrated failure of the facility to provide health care services.</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the provision of general care by making certain a client's bowel movements were comprehensively monitored and treatment was rendered consistently. Additionally, the facility failed to ensure a client received timely emergency medical services, for one of five clients in the investigation. (Client #5)</p> <p>The finding includes:</p> <p>1. The facility failed to ensure Client #5's order for milk of magnesia was clarified and understood to make certain it was administered consistently.</p> <p>Interview with the facility's former house manager on July 22, 2013, beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements.</p>	W 322			

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W 322	<p>Continued From page 50</p> <p>Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, at approximately 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Additional review of the client's POS from January 2013 through July 2013 revealed the client was prescribed medications including Surfak (for constipation discontinued on May 3, 2013), Ducosate Sodium (stool softener ordered to begin on May 3, 2013) and Milk of Magnesia (as needed for constipation).</p> <p>Review of the Client #5's record on July 30, 2013, at 2:50 p.m. revealed that client's daily bowel movement frequency was being documented by facility staff on a form entitled, "Bowel Elimination Record." According to the bowel movement records from January 2013 to July 2013, the following was noted:</p> <p>February 2013 2/9/13 - no bowel movement noted. The elimination record documented that milk of magnesium had been given. 2/16/13 - 2/18/13 - no bowel movement noted. The elimination record further documented that on 2/17/13, Client #5 "complained of stomach pain, sat on the toilet, but no bowel movement." 2/22/13 - 2/23/13 - no bowel movement noted.</p> <p>Review of the corresponding February 2013 MAR on July 30, 2013 beginning at 5:44 p.m. verified that MOM was administered on February 9, 2013. Continued review of the MAR revealed that the MOM was given at 7:00 p.m. for constipation. The nurse documented that the results of the medication was "effective" but, the nurse failed to document the time he/she verified the</p>	W 322	<p>The agency has developed a system to ensure that all individuals receive appropriate and timely medical attention and oversight.</p> <ul style="list-style-type: none"> <li>• The assigned caseload for the medication administration nursing staff has been reduced.</li> <li>• All nursing staff have received an in-service on telephone triaging – also received a text book – telephone triage</li> <li>• All nurses meet with the DON, for weekly training and submission of a weekly report on the status of the individuals in their case load.</li> <li>• The DON submits a weekly health status report to the senior management team.</li> <li>• The bowel movement management process has been revised to increase nurse oversight and accountability at the residential and day program locations.</li> <li>• The PRN laxative process and procedure has been developed for individuals receiving laxatives and for those individuals who need to have their BMs monitored on a daily basis</li> <li>• The medication nurse involved with this situation has been placed on administrative leave pending the closure of this investigation</li> <li>• A weekly system of RN Supervisor oversight of all MARs to ensure accuracy in medication administration.</li> <li>• All the nursing and direct support staff have been in-serviced on the following:</li> </ul>	

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W 322	<p>Continued From page 51</p> <p>medication's effectiveness. Furthermore, there was no evidence to support how the medication was determined to be effective.</p> <p>March 2013 3/10/13 - 3/12/13 - no bowel movement noted. The elimination record further documented that on 3/12/13, Client #5 "appeared as if he was attempting to have a bowel movement, just grunting." It should be noted that the record indicated the client had a small hard bowel movement on 3/13/13.</p> <p>Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:46 p.m. revealed no evidence that the MOM was given the entire month of March 2013.</p> <p>May 2013 5/5/13 - no bowel movement noted. 5/9/13 - 5/12/13 - no bowel movement noted. 5/24/13 - 5/26/13 - no bowel movement noted. 5/28/13 - 5/29/13 - no bowel movement noted. There was no area on the available bowel movement elimination record to document a description of the client's bowel elimination on 5/30/13 - 5/31/13.</p> <p>Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:50 p.m. revealed MOM was administered on May 12, 2013 (8:00 p.m.), May 26, 2013 (4:00 p.m.), and May 31, 2013 (6:00 p.m.), because the client had not had a bowel movement for three days. The nurse(s) documented that the results of the medication was "effective" on May 12, 2013 and May 31, 2013 but failed to document any results on May 26, 2013. Additionally, the nurse(s) failed to document the time he/she verified the</p>	W 322	<ul style="list-style-type: none"> <li>• Medication administration policy and procedure – address physician's signature for verbal orders, PRN orders, MARs – documentation of PRN orders and efficacy of PRN medication</li> <li>• Emergency medical procedure, transportation and notification process</li> <li>• 'PRN laxative' process and procedure and documentation</li> <li>• Daily BM monitoring procedure</li> <li>• Medication nurse schedule</li> <li>• 1:1 job description – function during emergencies</li> </ul>	8/25/13

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W 322	<p>Continued From page 52</p> <p>medication's effectiveness and exactly what constituted the medication's effectiveness.</p> <p>Interview was conducted with the facility's licensed practical nurse coordinator (LPN #1) on August 7, 2013 at 4:40 p.m. to ascertain information regarding the administration of the client's prescribed MOM. According to the LPN #1, the MOM is administered when Client #5 had not had a bowel movement for three consecutive days. Interview with the chief executive officer on August 8, 2013 at 4:05 p.m. verified that the MOM was to be given when the client had no bowel movement for three days. At the time of the investigation, the facility failed to ensure the client's order for MOM was clarified in order to ensure it was consistently administered as needed. Additionally, the facility failed to ensure nurses documented specified how the medication was effective and the date and time of the effectiveness.</p> <p>2. The facility's nursing personnel failed to ensure Client #5 received prescribed medications as ordered.</p> <p>Interview with the facility's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements.</p> <p>Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, beginning at 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Further review of the client's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to</p>	W 322			

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W 322	<p>Continued From page 53</p> <p>discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml), take 2 teaspoonful by mouth daily for stool softener."</p> <p>Review of the Client #5's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. failed to provide evidence that the client received the prescribed colace as ordered. According to the May 2013 MAR, Client #5 failed to receive the colace (to be initiated on May 3, 2013) for the entire month.</p> <p>3. The facility failed to ensure Client #5 received timely emergency medical services.</p> <p>Review of Client #5's record on July 30, 2013, at 3:00 p.m., revealed a nursing note dated June 29, 2013 (8:30 p.m.). According to the note, staff reported that Client #5 had experienced having "loose stools all day." The note further reflected that the client had not eaten, was "barely drinking anything and [was] un-alert (passing out every now and then). Continued review of the note revealed that staff indicated that the client was "still seeping out stool and was not able to leave the bathroom or remain alert."</p> <p>Additional review of the June 29, 2013 nursing note revealed that Client #3's primary care physician (PCP) was notified at 8:34 p.m. and ordered that the client be sent to the emergency room due to his "level of consciousness."</p> <p>Interview was conducted with direct support professional (DSP) #12 on August 8, 2013, beginning at 3:35 p.m. According to DSP #12, Client #5 was observed to have fainted twice while in the shower during evening care shortly</p>	W 322		

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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>07/26/2013</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 322	Continued From page 54 after 8:00 p.m. DSP #12 confirmed that Client #5 had been observed having loose stools all day. Continued discussion with DSP #12 revealed that he/she immediately notified the licensed practical nurse coordinator (LPNC), via telephone, of the client's condition. DSP #12 revealed that LPNC called back at approximately 9:00 p.m. (an hour later) and instructed the staff member to transport Client #5 to the emergency room. Further discussion with DSP #12 revealed that the LPNC was informed that there was only two staff in the facility and if a staff person left there would not be enough staff present to supervise the client's that remained home. According to DSP #12, Client #5 had to wait in the facility until the house manager arrived in order to be escorted to the emergency room. DSP #12 revealed that the house manager arrived to the facility at 11:00 p.m. (three hours after the incident occurred). At the time of the investigation, the facility failed to ensure Client #5 received timely emergency medical services.  Note: According to DSP #12, DSP #5 escorted Client #5 to the hospital in the cliential van alone. It should be further noted that Client #5 receives 1:1 staffing support, 16 hours per day, seven days per week. (See also W186)	W 322			
W 331	483.460(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that (1) nursing personnel provided each client with prescribed medications	W 331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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W 331	<p>Continued From page 55 as ordered; and (2) failed to ensure a client's bowel movements were comprehensively monitored and treatment was rendered consistently. for one of three clients residing in the facility. (Client #5)</p> <p>The findings include:</p> <p>1. The facility's nursing personnel failed to ensure Client #5 received prescribed medications as ordered.</p> <p>Interview with the facility's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements.</p> <p>Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, beginning at 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Further review of the client's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml), take 2 teaspoonful by mouth daily for stool softener."</p> <p>Review of the Client #5's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. failed to provide evidence that the client received the prescribed colace as ordered. According to the May 2013 MAR, Client #5 failed to receive the colace (to be initiated on May 3, 2013) for the entire month.</p> <p>2. The facility nursing personnel failed to ensure Client #5's order for milk of magnesia was</p>	W 331	<p>W 331</p> <p>Refer W 318,322</p>	
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W 331	<p>Continued From page 56 clarified to make certain it was administered consistently.</p> <p>Interview with the facility's former house manager on July 22, 2013, beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements.</p> <p>Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, at approximately 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Additional review of the client's POS from January 2013 through July 2013 revealed the client was prescribed medications including Surfak (for constipation discontinued on May 3, 2013), Ducosate Sodium (stool softener ordered to begin on May 3, 2013) and Milk of Magnesia (as needed for constipation).</p> <p>Review of the Client #5's record on July 30, 2013, at 2:50 p.m. revealed that client's daily bowel movement frequency was being documented by facility staff on a form entitled, "Bowel Elimination Record." According to the bowel movement records from January 2013 to July 2013, the following was noted:</p> <p>February 2013 2/9/13 - no bowel movement noted. The elimination record documented that milk of magnesium had been given. 2/16/13 - 2/18/13 - no bowel movement noted. The elimination record further documented that on 2/17/13, Client #5 "complained of stomach pain, sat on the toilet, but no bowel movement." 2/22/13 -2/23/13 - no bowel movement noted.</p>	W 331			

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W 331	<p>Continued From page 57</p> <p>Review of the corresponding February 2013 MAR on July 30, 2013 beginning at 5:44 p.m. verified that MOM was administered on February 9, 2013. Continued review of the MAR revealed that the MOM was given at 7:00 p.m. for constipation. The nurse documented that the results of the medication was "effective" but, the nurse failed to document the time he/she verified the medication's effectiveness. Furthermore, there was no evidence to support how the medication was determined to be effective.</p> <p>March 2013 3/10/13 - 3/12/13 - no bowel movement noted. The elimination record further documented that on 3/12/13, Client #5 "appeared as if he was attempting to have a bowel movement, just grunting." It should be noted that the record indicated the client had a small hard bowel movement on 3/13/13.</p> <p>Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:46 p.m. revealed no evidence that the MOM was given the entire month of March 2013.</p> <p>May 2013 5/5/13 - no bowel movement noted. 5/9/13 - 5/12/13 - no bowel movement noted. 5/24/13 - 5/26/13 - no bowel movement noted. 5/28/13 - 5/29/13 - no bowel movement noted. There was no area on the available bowel movement elimination record to document a description of the client's bowel elimination on 5/30/13 - 5/31/13.</p> <p>Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:50 p.m. revealed MOM was administered on May 12, 2013 (8:00</p>	W 331			

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W 331	Continued From page 58 p.m.), May 26, 2013 (4:00 p.m.), and May 31, 2013 (6:00 p.m.), because the client had not had a bowel movement for three days. The nurse(s) documented that the results of the medication was "effective" on May 12, 2013 and May 31, 2013 but failed to document any results on May 26, 2013. Additionally, the nurse(s) failed to document the time he/she verified the medication's effectiveness and exactly what constituted the medication's effectiveness.  Interview was conducted with the facility's licensed practical nurse coordinator (LPN #1) on August 7, 2013 at 4:40 p.m. to ascertain information regarding the administration of the client's prescribed MOM. According to the LPN #1, the MOM is administered when Client #5 had not had a bowel movement for three consecutive days. Interview with the chief executive officer on August 8, 2013 at 4:05 p.m. verified that the MOM was to be given when the client had no bowel movement for three days. At the time of the investigation, the facility failed to ensure the client's order for MOM was clarified in order to ensure it was consistently administered as needed. Additionally, the facility failed to ensure nurses documented specified how the medication was effective and the date and time of the effectiveness.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on observation, interview and record	W 368		

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W 368	<p>Continued From page 59</p> <p>review, the facility failed to ensure that a client's stool softener was administered in accordance with physician's orders, for one of three clients residing in the facility. (Client #1)</p> <p>The findings include:</p> <p>Interview with the facility's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #3's bowel movements.</p> <p>Review of Client #3's July 2013 physician's orders (POS) on July 30, 2013, at 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Further review of the client's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml), take 2 teaspoonful by mouth daily for stool softener."</p> <p>Review of the Client #3's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. revealed no evidence that the prescribed colace had been administered during the month of May 2013. The May 2013 MAR however, verified the discontinuance of the Surfak on May 3, 2013.</p> <p>At the time of the investigation, the facility failed to provide evidence that Client #3's prescribed colace was initiated during the month of May 2013 as ordered.</p>	W 368	<p>W 368</p> <p>Refer W 318,322,368</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0206	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/26/2013
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOULTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>On July 9, 2013, at 2:58 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (OCAQID), was notified by telephone of an unusual incident that occurred on the morning of July 9, 2013, at approximately 8:25 p.m. The caller revealed that Resident #1 sustained a severe injury to the right eye. During the investigative process on July 10, 2013, an incident occurred during the 4:00 p.m. - 12:00 a.m. shift where Resident #2 sustained a severe injury to his right eye and was transported to the emergency room via 911.</p> <p>Due to the nature of the information obtained, the Health Regulation and Licensing Administration's (HRLA), Intermediate Care Facilities Division initiated an on-site incident investigation on July 9, 2013. The purpose of the investigation was to determine if the GHIID was in compliance with the regulatory standards.</p> <p>The findings of this investigation were based on interviews with GHIID staff, review of the agency's administrative records, including the review of the incident management system.</p> <p>As a result of the investigation, a determination was made on July 26, 2013, that the GHIID failed to ensure compliance with the federal conditions of participation of governing body, client protection, GHIID staffing, and health care services. The state agency informed the GHIID's chief executive officer (CEO) and chief operating officer (COO) of the determination on July 26, 2013, at approximately 11:30 a.m.</p> <p>[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within</p>	1 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Guan J. Sloan*

TITLE

*COO*

(X6) DATE

*8/29/13*

Health Regulation & Licensing Administration

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I 000	Continued From page 1 this report.]	I 000		
I 180	<p><b>3508.1 ADMINISTRATIVE SUPPORT</b></p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to provide adequate administrative support to ensure effective integration and coordination of each resident's habilitation and active treatment needs, for two of the five residents residing in the GHIID. (Residents #1 and #2)</p> <p>The findings include: [Cross refer to W159]</p> <p>On July 9, 2019, at 2:58 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (OCAQID), was notified by telephone of an unusual incident that occurred on the morning of July 9, 2013, at approximately 8:25 p.m. The caller revealed that Resident #1 sustained a severe injury to the right eye. During the investigative process on July 10, 2013, a second incident occurred involving Resident #2 during the 4:00 p.m. to 12:00 a.m. shift. According to the information provided, Resident #2 sustained a severe injury to his right eye and was transported to the emergency room via 911.</p> <p>An onsite incident investigation was initiated on</p>	I 180	<p>I 180</p> <p>All staff were re in-serviced on the BSP, CPI and 1:1 training. The psychologist will be providing on-going training to equip the staff in recognizing attachment needs, non-verbal communication, positive behavioral supports, emotional vs intelligence expression, executive functioning, therapeutic activities and games and learning principles. These training courses will be provided to the staff on an on-going basis.</p> <p>Attached:</p> <ul style="list-style-type: none"> <li>• In service – BSP and CPI</li> <li>• Introduction to Mental Health, group dynamics, activity therapies, general psychology, human growth &amp; development, child &amp; adolescent psychology, introduction to abnormal psychology and educational psychology</li> <li>- Course outline and schedule</li> <li>• Active Treatment</li> <li>• 1:1 job description and training</li> </ul>	8/27/13

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I 180	<p>Continued From page 2</p> <p>July 9, 2013. The results of the investigation revealed, the QIDP failed to coordinate and integrate services as indicated below:</p> <p>1. [Cross refer to W249]. The QIDP failed to ensure staff implemented proactive strategies that were outlined in Resident #1's behavior support plan (BSP).</p> <p>In a face to face interview with DSP #1 on July 10, 2013, beginning at 9:48 a.m., the staff member revealed he/she was assigned to Resident #1 as his one to one (1:1) staffing support on the morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the resident's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Resident #1 was sitting in a chair in the living room drinking coffee and was observed to "smack" himself on the right side of his face with his right hand five (5) times. DSP #1 stated that Resident #1 was redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Resident #1 began hitting himself again "extremely hard" on the right side of his face non-stop to the point where swelling was observed underneath his right eye and on the right side of his face. DSP #1 stated DSP #3 verbally prompted Resident #2 to stop, but the resident did not respond and continued to hit himself. DSP #1 stated that she provided no other intervention. When queried about implementing the BSP, DSP #1 replied by saying, "I was shocked! What could I do, he's stronger than I am." DSP #1 stated that she had received training on Resident #1's behavior support plan (BSP) and crisis prevention interventions (CPI).</p> <p>Interview with DSP #2 on July 10, 2013, beginning at 10:44 a.m. revealed that on the</p>	I 180		

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I 180	<p>Continued From page 3</p> <p>morning of July 9, 2013, she provided Resident #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Resident #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the resident to stop. According to DSP #2, Resident #1 stopped hitting himself and finished his coffee. DSP #2 stated that Resident #1 "signed for another cup of coffee" but did not get it. At 8:25 a.m., DSP #2 stated that Resident #1 began slapping himself with his right hand to the right side of his face "extremely hard". The slaps were "very loud and it was scary. I was shocked!" DSP #2 stated that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Resident #1 and verbally prompted the resident to calm down but was unsuccessful.</p> <p>Interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Resident #2. DSP #3 revealed that he was positioned in the living room with Resident #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Resident #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Resident #1's 1:1 support staff) jumped up and moved away from Resident #1. DSP #3 verbally prompted the [resident] to calm down and asked, "Are you ok?" DSP #3 then stated that Resident #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the resident and placed the resident's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his resident, Resident #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get</p>	I 180		

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I 180	<p>Continued From page 4</p> <p>Resident #1 some water. DSP #3 went back over to Resident #1 and the resident used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Resident #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Resident #1 hit himself a few more time. DSP #3 stated that he walked over to Resident #1 and stated, "That's enough" in a firm voice.</p> <p>On July 10, 2013, beginning at approximately 5:10 p.m., review of Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical aggression, SIB (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision is needed for behavior support implementation, and to ensure the safety of the resident, given the high level of risk of several of his target behaviors. Continued review of the BSP revealed that if Resident #1 engaged in SIB, staff should implement the following proactive strategies:</p> <p>a. Whenever possible, he [resident] should be redirected before he actually attempts to engage him in this behavior.</p> <p>b. As soon as it is feasible, staff should attempt to identify the stimulus for this behavior. This includes if Resident #1 is only beginning to become agitated. If a stimulus can be ID, staff should attempt to address this as soon as possible.</p> <p>c. If Resident #1 begins to engage in SIB, staff should first attempt to verbally redirect him away from this and toward an activity. For example,</p>	I 180		

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I 180	<p>Continued From page 5</p> <p>staff may offer to take the resident for a walk, offer an activity using his hands, assist with the laundry, offer choices, etc. Staff may say in a calm but firm voice, "Please stop (state behavior)!"</p> <p>d. If the resident does not respond to verbal redirection and continues to engage in SIB, staff should refer to the crisis intervention plan.</p> <p>Review of the crisis intervention plan revealed that if Resident #1 became agitated and began to present a danger to himself or others, staff may use the least restrictive, least intrusive strategy possible. Implement a program-approved by the GHIID. For example, staff could use supportive physical techniques, one or two person escort and/or any relevant blocks or releases to assist Resident #1.</p> <p>2. The QIDP failed to ensure Residents #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following:</p> <p>a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Resident #2 as his one to one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all residents were in bed asleep. At approximately 10:30 p.m., DSP #8 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8</p>	I 180		

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I 180	<p>Continued From page 6</p> <p>stated that while walking back upstairs, he heard a thump/shuffle that came from Resident #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the resident's room. As he stepped inside the bedroom, he indicated he witnessed Resident #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the resident's injury he said, "I'm going to get the first aid kit." Resident #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911 emergency services. As a result of the injury, Resident #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Resident #2 at all times in accordance with the BSP.</p> <p>On July 11, 2013, at approximately 5:00 p.m., review of Resident #2's BSP dated April 13, 2013, revealed that although the resident was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Resident #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the resident. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident during awaking hours.</p> <p>b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Resident #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Resident #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated</p>	I 180		

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I 180	<p>Continued From page 7</p> <p>that DSP #8 informed him that he was going downstairs to work on the laundry and to get the mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the resident went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Resident #1's bedroom and checked on him every 30 minutes.</p> <p>On July 10, 2013, beginning at approximately 5:10 p.m., review of the Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the resident, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident during awaking hours.</p> <p>Note: It should be noted that on July 18, 2013, beginning at 10:50 a.m., interview with the former residential counselor (RC) revealed that it was her expectation that 1:1 staff were to remain within arm's length of their assigned residents throughout their shift. A telephone interview conducted with the former qualified intellectual disabilities professional on July 19, 2013, beginning at 1:33 p.m., verified the former RC's interview.</p> <p>2. The QIDP failed to integrate services to ensure Resident #3 received 1:1 support services as recommended.</p>	I 180		

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I 180	<p>Continued From page 8</p> <p>Interview with the former residential coordinator (RC) on July 18, 2013 beginning at 10:50 a.m. revealed that there were five residents residing in the GHIID. According to the former RC, three of the residents currently receive 1:1 staffing supports, sixteen hours per day, seven days a week. The former RC further revealed that Resident #3 was recommended to receive 1:1 staffing support but didn't because the GHIID was not being compensated for that service. Further discussion with the RC and review of Resident #3's record on July 19, 2013 at approximately 12:31 p.m. revealed the resident's individual support plan dated May 13, 2013, document 1:1 supervision was recommended. Further review of the resident's record revealed a psychological assessment dated April 7, 2013 that documented, "Given [the resident's] current gait deficits, it is recommended that he receive one to one staff support to ensure his safety."</p> <p>Interview with the former QIDP on June 19, 2013 beginning at 1:19 p.m. revealed that she was aware of the recommendation. According to the former QIDP, the 1:1 had not been implemented at the time of the investigation.</p>	I 180		
I 246	<p>3511.4 DIRECT CARE STAFF RATIOS</p> <p>The initial daily direct care staff ratios shall be determined by the Department of Human Services (DHS) based upon the characteristics of the individuals proposed to be served or served by the GHMRP as described in the Individual Habilitation Plans or based upon the GHMRP 's description of the individuals to be served.</p> <p>This Statute is not met as evidenced by:</p>	I 246		

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I 246	<p>Continued From page 9</p> <p>Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to provide sufficient staffing and one to one (1:1) supervision to protect residents from harm and to ensure their safety, for two of the four residents in the investigation. (Residents #1 and #2)</p> <p>The findings include:</p> <p>During the course of an investigation initiated on July 9, 2013, it was discovered that on July 10, 2013, Resident #2 fell on his bathroom floor at 11:50 p.m. The resident was taken to the emergency room via 911 and received several stitches to his right eyebrow.</p> <p>Direct Support Professional (DSP) #8 and DSP #4 failed to ensure Residents #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following:</p> <p>a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Resident #2 as his one to one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all residents were in bed asleep. At approximately 10:30 p.m., DSP #8 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8 stated that while walking back upstairs, he heard a thump/shuffle that came from Resident #2's</p>	I 246	<p>I 246</p> <p>The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant and the staffing ratios meet the regulatory standards. The QIDP and Facility Manager have been in-serviced on monitoring the schedule daily and notifying the HR department for relief or supplemental staffing for vacancies or call-outs.</p> <p>In the future the Facility Manager and the QIDP will ensure that there is daily oversight of the staff so as to maintain the required ratios to remain compliant and provide safety.</p> <p>Attached :</p> <ul style="list-style-type: none"> <li>• Staff schedule</li> <li>• Course outline and schedule</li> <li>• Active Treatment</li> <li>• 1:1 job description and training</li> <li>• BSP &amp; CPI training</li> <li>• Staff schedule</li> <li>• PT in-service</li> <li>• Active treatment</li> <li>• HRC – emergency approval for interim 1:1 staff</li> <li>• Acuity package to DHCF – receipt</li> <li>• Disciplinary action for involved staff</li> </ul>	8/26/13

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I 246	Continued From page 10  bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the resident's room. As he stepped inside the bedroom, he indicated he witnessed Resident #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the resident's injury he said, "I'm going to get the first aid kit." Resident #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911 emergency services. As a result of the injury, Resident #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Resident #2 at all times in accordance with the BSP.  On July 11, 2013, at approximately 5:00 p.m., review of Resident #2's BSP dated April 13, 2013, revealed that although the resident was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Resident #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the resident. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident during awaking hours.  b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Resident #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Resident #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated that DSP #8 informed him that he was going downstairs to work on the laundry and to get the	I 246		

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I 246	<p>Continued From page 11</p> <p>mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the resident went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Resident #1's bedroom and checked on him every 30 minutes.</p> <p>On July 10, 2013, beginning at approximately 5:10 p.m., review of the Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the resident, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident during awaking hours.</p> <p>On July 11, 2013, at approximately 4:00 p.m., review of the staff training records revealed all staff had received training on Resident #1's and Resident #2's BSP on June 20, 2013. However, there was no evidence that training had been effective.</p> <p>Note: Interview with the GHID's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Residents #1 and #2 received one to one (1:1) staffing support 16 hours per day, 7 days a week. According to the former RC, the residents were to receive arm's length 1:1 staffing support from 8:00 a.m. through 12:00 a.m., which was considered waking hours. Interview with the former qualified intellectual disabilities professional (QIDP) on July 19, 2013, via</p>	I 246		

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I 246	Continued From page 12 telephone, verified the former RC's statement.	I 246		
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 interview and record review, the group home for individual with intellectual disabilities (GHIID) failed to ensure the provision of general care by making certain a resident's bowel movements were comprehensively monitored and treatment was rendered consistently. Additionally, the GHIID failed to ensure a resident received timely emergency medical services, for one of five residents in the investigation. (Resident #5)</p> <p>The findings include:</p> <p>[Cross refer to W322]</p> <p>1. The GHIID failed to ensure Resident #5's order for milk of magnesia was clarified and understood to make certain it was administered consistently.</p> <p>Interview with the GHIID's former house manager on July 22, 2013, beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Resident</p>	I 401	<p>I 401</p> <p>The agency has developed a system to ensure that all individuals receive appropriate and timely medical attention and oversight.</p> <ul style="list-style-type: none"> <li>• The assigned caseload for the medication administration nursing staff has been reduced.</li> <li>• All nursing staff have received an in-service on telephone triaging – also received a text book – telephone triage</li> <li>• All nurses meet with the DON, for weekly training and submission of a weekly report on the status of the individuals in their case load.</li> <li>• The DON submits a weekly health status report to the senior management team.</li> <li>• The bowel movement management process has been revised to increase nurse oversight and accountability at the residential and day program locations.</li> <li>• The PRN laxative process and procedure has been developed for individuals receiving laxatives and for those individuals who need to have their BMs monitored on a daily basis</li> </ul>	8/22/13

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I 401	<p>Continued From page 13</p> <p>#5's bowel movements.</p> <p>Review of Resident #5's July 2013 physician's orders (POS) on July 30, 2013, at approximately 4:02 p.m. revealed the resident had diagnoses that included sigmoid diverticula. Additional review of the resident's POS from January 2013 through July 2013 revealed the resident was prescribed medications including Surfak (for constipation discontinued on May 3, 2013), Ducosate Sodium (stool softener ordered to begin on May 3, 2013) and Milk of Magnesia (as needed for constipation).</p> <p>Review of the Resident #5's record on July 30, 2013, at 2:50 p.m. revealed that resident's daily bowel movement frequency was being documented by GHIID staff on a form entitled, "Bowel Elimination Record." According to the bowel movement records from January 2013 to July 2013, the following was noted:</p> <p>February 2013 2/9/13 - no bowel movement noted. The elimination record documented that milk of magnesium had been given. 2/16/13 - 2/18/13 - no bowel movement noted. The elimination record further documented that on 2/17/13, Resident #5 "complained of stomach pain, sat on the toilet, but no bowel movement." 2/22/13 -2/23/13 - no bowel movement noted.</p> <p>Review of the corresponding February 2013 MAR on July 30, 2013 beginning at 5:44 p.m. verified that MOM was administered on February 9, 2013. Continued review of the MAR revealed that the MOM was given at 7:00 p.m. for constipation. The nurse documented that the results of the medication was "effective" but, the nurse failed to document the time he/she verified the</p>	I 401	<ul style="list-style-type: none"> <li>• The medication nurse involved with this situation has been placed on administrative leave pending the closure of this investigation</li> <li>• A weekly system of RN Supervisor oversight of all MARs to ensure accuracy in medication administration.</li> <li>• All the nursing and direct support staff have been in-serviced on the following:</li> <li>• Medication administration policy and procedure – address physician's signature for verbal orders, PRN orders, MARs – documentation of PRN orders and efficacy of PRN medication</li> <li>• Emergency medical procedure, transportation and notification process</li> <li>• 'PRN laxative' process and procedure and documentation</li> <li>• Daily BM monitoring procedure</li> <li>• Medication nurse schedule</li> <li>• 1:1 job description – function during emergencies</li> </ul>	

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I 401	<p>Continued From page 14</p> <p>medication's effectiveness. Furthermore, there was no evidence to support how the medication was determined to be effective.</p> <p>March 2013 3/10/13 - 3/12/13 - no bowel movement noted. The elimination record further documented that on 3/12/13, Resident #5 "appeared as if he was attempting to have a bowel movement, just grunting." It should be noted that the record indicated the resident had a small hard bowel movement on 3/13/13.</p> <p>Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:46 p.m. revealed no evidence that the MOM was given the entire month of March 2013.</p> <p>May 2013 5/5/13 - no bowel movement noted. 5/9/13 - 5/12/13 - no bowel movement noted. 5/24/13 - 5/26/13 - no bowel movement noted. 5/28/13 - 5/29/13 - no bowel movement noted. There was no area on the available bowel movement elimination record to document a description of the resident's bowel elimination on 5/30/13 - 5/31/13.</p> <p>Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:50 p.m. revealed MOM was administered on May 12, 2013 (8:00 p.m.), May 26, 2013 (4:00 p.m.), and May 31, 2013 (6:00 p.m.), because the resident had not had a bowel movement for three days. The nurse(s) documented that the results of the medication was "effective" on May 12, 2013 and May 31, 2013 but failed to document any results on May 26, 2013. Additionally, the nurse(s) failed to document the time he/she verified the medication's effectiveness and exactly what</p>	I 401		

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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOULTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012
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I 401	<p>Continued From page 15</p> <p>constituted the medication's effectiveness.</p> <p>Interview was conducted with the GHIID's licensed practical nurse coordinator (LPN #1) on August 7, 2013 at 4:40 p.m. to ascertain information regarding the administration of the resident's prescribed MOM. According to the LPN #1, the MOM is administered when Resident #5 had not had a bowel movement for three consecutive days. Interview with the chief executive officer on August 8, 2013 at 4:05 p.m. verified that the MOM was to be given when the resident had no bowel movement for three days. At the time of the investigation, the GHIID failed to ensure the resident's order for MOM was clarified in order to ensure it was consistently administered as needed. Additionally, the GHIID failed to ensure nurses documented specified how the medication was effective and the date and time of the effectiveness.</p> <p>2. The GHIID's nursing personnel failed to ensure Resident #5 received prescribed medications as ordered.</p> <p>Interview with the GHIID's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Resident #5's bowel movements.</p> <p>Review of Resident #5's July 2013 physician's orders (POS) on July 30, 2013, beginning at 4:02 p.m. revealed the resident had diagnoses that included sigmoid diverticula. Further review of the resident's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml),</p>	I 401		

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I 401	<p>Continued From page 16</p> <p>take 2 teaspoonful by mouth daily for stool softener."</p> <p>Review of the Resident #5's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. failed to provide evidence that the resident received the prescribed colace as ordered. According to the May 2013 MAR, Resident #5 failed to receive the colace (to be initiated on May 3, 2013) for the entire month.</p> <p>3. The GHIID failed to ensure Resident #5 received timely emergency medical services.</p> <p>Review of Resident #5's record on July 30, 2013, at 3:00 p.m., revealed a nursing note dated June 29, 2013 (8:30 p.m.). According to the note, staff reported that Resident #5 had experienced having "loose stools all day." The note further reflected that the resident had not eaten, was "barely drinking anything and [was] un-alert (passing out every now and then). Continued review of the note revealed that staff indicated that the resident was "still seeping out stool and was not able to leave the bathroom or remain alert."</p> <p>Additional review of the June 29, 2013 nursing note revealed that Resident #3's primary care physician (PCP) was notified at 8:34 p.m. and ordered that the resident be sent to the emergency room due to his "level of consciousness."</p> <p>Interview was conducted with direct support professional (DSP) #12 on August 8, 2013, beginning at 3:35 p.m. According to DSP #12, Resident #5 was observed to have fainted twice while in the shower during evening care shortly</p>	I 401		

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I 401	Continued From page 17  after 8:00 p.m. DSP #12 confirmed that Resident #5 had been observed having loose stools all day. Continued discussion with DSP #12 revealed that he/she immediately notified the licensed practical nurse coordinator (LPNC), via telephone, of the resident's condition. DSP #12 revealed that LPNC called back at approximately 9:00 p.m. (an hour later) and instructed the staff member to transport Resident #5 to the emergency room. Further discussion with DSP #12 revealed that the LPNC was informed that there was only two staff in the GHIID and if a staff person left there would not be enough staff present to supervise the resident's that remained home. According to DSP #12, Resident #5 had to wait in the GHIID until the house manager arrived in order to be escorted to the emergency room. DSP #12 revealed that the house manager arrived to the GHIID at 11:00 p.m. (three hours after the incident occurred). At the time of the investigation, the GHIID failed to ensure Resident #5 received timely emergency medical services.  Note: According to DSP #12, DSP #5 escorted Resident #5 to the hospital in the residential van alone. It should be further noted that Resident #5 receives 1:1 staffing support, 16 hours per day, seven days per week. (See also W186)	I 401		
I 422	3521.3 HABILITATION AND TRAINING  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 (GHIID) staff failed to	I 422		

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I 422	<p>Continued From page 18</p> <p>ensure each resident's behavior support plan (BSP) was implemented consistently, for two of the four residents in the investigation with maladaptive behaviors. (Residents #1 and #2)</p> <p>The findings include:</p> <p>[Cross refer W249]</p> <p>1. On July 9, 2013, the GHIID staff failed to implement proactive strategies that were outlined in Resident #1's behavior support plan (BSP), as evidenced by the following:</p> <p>In a face to face interview with DSP #1 on July 10, 2013, beginning at 9:48 a.m., the staff member revealed he/she was assigned to Resident #1 as his one to one (1:1) staffing support on the morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the resident's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Resident #1 was sitting in a chair in the living room drinking coffee and was observed to "smack" himself on the right side of his face with his right hand five (5) times. DSP #1 stated that Resident #1 was redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Resident #1 began hitting himself again "extremely hard" on the right side of his face non-stop to the point where swelling was observed underneath his right eye and on the right side of his face. DSP #1 stated DSP #3 verbally prompted Resident #2 to stop, but the resident did not respond and continued to hit himself. DSP #1 stated that she provided no other intervention. When queried about implementing the BSP, DSP #1 replied by saying, "I was shocked! What could I do, he's stronger than I am." DSP #1 stated that she had received</p>	I 422	<p>I 422</p> <p>All staff were re in-serviced on the BSP, CPI and 1:1 training. The psychologist will be providing on-going training to equip the staff in recognizing attachment needs, non-verbal communication, positive behavioral supports, emotional vs intelligence expression, executive functioning, therapeutic activities and games and learning principles. These training courses will be provided to the staff on an on-going basis.</p> <p>Attached:</p> <ul style="list-style-type: none"> <li>• In service – BSP and CPI</li> <li>• Introduction to Mental Health, group dynamics, activity therapies, general psychology, human growth &amp; development, child &amp; adolescent psychology, introduction to abnormal psychology and educational psychology - Course outline and schedule</li> <li>• Active Treatment</li> <li>• 1:1 job description and training</li> </ul>	8/26/13
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I 422	<p>Continued From page 19</p> <p>training on Resident #1's behavior support plan (BSP) and crisis prevention interventions (CPI).</p> <p>Interview with DSP #2 on July 10, 2013, beginning at 10:44 a.m. revealed that on the morning of July 9, 2013, she provided Resident #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Resident #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the resident to stop. According to DSP #2, Resident #1 stopped hitting himself and finished his coffee. DSP #2 stated that Resident #1 "signed for another cup of coffee" but did not get it. At 8:25 a.m., DSP #2 stated that Resident #1 began slapping himself with his right hand to the right side of his face "extremely hard". The slaps were "very loud and it was scary. I was shocked!" DSP #2 stated that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Resident #1 and verbally prompted the resident to calm down but was unsuccessful.</p> <p>Interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Resident #2. DSP #3 revealed that he was positioned in the living room with Resident #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Resident #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Resident #1's 1:1 support staff) jumped up and moved away from Resident #1. DSP #3 verbally prompted the [resident] to calm down and asked, "Are you ok?" DSP #3 then stated that Resident #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the resident and placed the</p>	I 422		

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I 422	<p>Continued From page 20</p> <p>resident's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his resident, Resident #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Resident #1 some water. DSP #3 went back over to Resident #1 and the resident used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Resident #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Resident #1 hit himself a few more time. DSP #3 stated that he walked over to Resident #1 and stated, "That's enough" in a firm voice.</p> <p>On July 10, 2013, beginning at approximately 5:10 p.m., review of Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical aggression, SIB (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision is needed for behavior support implementation, and to ensure the safety of the resident, given the high level of risk of several of his target behaviors. Continued review of the BSP revealed that if Resident #1 engaged in SIB, staff should implement the following proactive strategies:</p> <p>a. Whenever possible, he [resident] should be redirected before he actually attempts to engage him in this behavior.</p> <p>b. As soon as it is feasible, staff should attempt to identify the stimulus for this behavior. This includes if Resident #1 is only beginning to become agitated. If a stimulus can be ID, staff should attempt to address this as soon as</p>	I 422		

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I 422	<p>Continued From page 21</p> <p>possible.</p> <p>c. If Resident #1 begins to engage in SIB, staff should first attempt to verbally redirect him away from this and toward an activity. For example, staff may offer to take the resident for a walk, offer an activity using his hands, assist with the laundry, offer choices, etc. Staff may say in a calm but firm voice, "Please stop (state behavior)!"</p> <p>d. If the resident does not respond to verbal redirection and continues to engage in SIB, staff should refer to the crisis intervention plan.</p> <p>Review of the crisis intervention plan revealed that if Resident #1 became agitated and began to present a danger to himself or others, staff may use the least restrictive, least intrusive strategy possible. Implement a program-approved by the GHIID. For example, staff could use supportive physical techniques, one or two person escort and/or any relevant blocks or releases to assist Resident #1.</p> <p>At the time of the investigation, the GHIID failed to ensure Resident #1's BSP was implemented as outlined.</p> <p>2. Direct Support Professional (DSP) #8 and DSP #4 failed to ensure Residents #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following:</p> <p>a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Resident #2 as his one to</p>	I 422		

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I 422	<p>Continued From page 22</p> <p>one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all residents were in bed asleep. At approximately 10:30 p.m., DSP #8 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8 stated that while walking back upstairs, he heard a thump/shuffle that came from Resident #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the resident's room. As he stepped inside the bedroom, he indicated he witnessed Resident #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the resident's injury he said, "I'm going to get the first aid kit." Resident #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911 emergency services. As a result of the injury, Resident #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Resident #2 at all times in accordance with the BSP.</p> <p>On July 11, 2013, at approximately 5:00 p.m., review of Resident #2's BSP dated April 13, 2013, revealed that although the resident was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Resident #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the resident. The BSP also added that 1:1 support staff should</p>	I 422		

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I 422	<p>Continued From page 23</p> <p>be between arm's length and five feet from the resident during awaking hours.</p> <p>b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Resident #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Resident #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated that DSP #8 informed him that he was going downstairs to work on the laundry and to get the mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the resident went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Resident #1's bedroom and checked on him every 30 minutes.</p> <p>On July 10, 2013, beginning at approximately 5:10 p.m., review of the Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the resident, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident during awaking hours.</p> <p>Note: It should be noted that on July 18, 2013, beginning at 10:50 a.m., interview with the former residential counselor (RC) revealed that it was</p>	I 422		
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I 422	Continued From page 24  her expectation that 1:1 staff were to remain within arm's length of their assigned residents throughout their shift. A telephone interview conducted with the former qualified intellectual disabilities professional on July 19, 2013, beginning at 1:33 p.m., verified the former RC's interview.	I 422		
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 group home for individuals with intellectual disabilities (GHIID) 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) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for one of four residents in the investigations. (Resident #2)</p> <p>The finding includes:</p> <p>On July 10, 2013, during the 4:00 p.m. - 12:00 a.m. shift, Resident #2 fell in his bathroom at approximately 11:50 p.m. causing a severe injury to his right eye. Resident #2 was transported by emergency medical services to a local hospital's emergency room and kept overnight for observation. Interview with staff and the review of the GHIID's internal investigation revealed the</p>	I 500	<p>I 500</p> <p>The staffs involved were disciplined, terminated, re-trained and/or transferred out from the facility.</p> <p>All staff were in-serviced on individuals' rights, abuse &amp; neglect, emergency procedure and communication, ADLs, BSP and Introduction to Mental Health, human development and psychology.</p> <p>Attached :</p> <ul style="list-style-type: none"> <li>• Staff schedule</li> <li>• Abuse/neglect</li> <li>• Individuals' rights</li> <li>• Emergency medical procedure</li> <li>• Course outline and schedule</li> <li>• 1:1 job description and training</li> <li>• BSP &amp; CPI training</li> <li>• Staff schedule</li> <li>• PT in-service</li> <li>• Active treatment</li> <li>• HRC – emergency approval for interim 1:1 staff</li> <li>• Acuity package to DHCF – receipt</li> <li>• Disciplinary action for involved staff</li> </ul>	8/25/13

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I 500	<p>Continued From page 25</p> <p>resident received eleven sutures to the right eye.</p> <p>On July 11, 2013, at 8:40 p.m., interview conducted with direct support professional (DSP) #4 revealed he was assigned to work with Resident #1 on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. Further interview revealed that when he arrived to work on July 10, 2013, DSP #5 was assigned to Resident #2 as his one to one (1:1) staff. After dinner between 7:00 p.m. and 8:00 p.m., DSP #4 stated that he heard Resident #2 mutter shower repeatedly. DSP #4 stated that DSP #5 did not give Resident #2 a shower prior to leaving his shift at 9:00 p.m. As a result of not receiving a shower, DSP #4 stated that Resident #2 remained awake and muttered shower throughout the night.</p> <p>On July 15, 2013, beginning at 10:10 a.m., interview with DSP #5 revealed he was Client #2's 1:1 support staff from 12:35 p.m. to 9:00 p.m. on July 10, 2013. DSP #5 confirmed during his interview that he did not shower the resident after dinner although the resident was asking to be showered. DSP #5 did state however, that the resident was showered earlier that evening at approximately 5:00 p.m. after having a bowel movement (BM) accident.</p> <p>On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 (assigned to Resident #2 as his 1:1 staff on July 10, 2013) revealed that while preparing the resident for the emergency medical services; he noticed that the resident's undergarments were soiled. He stated that he did not check to see if Resident #2's undergarment was soiled after his arrival to work at 9:09 p.m. DSP #8 stated that the resident wanted a shower and that's probably why he was awake and tried to go to the bathroom to take a</p>	I 500		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0206	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/26/2013
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOULTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7416 BLAIR ROAD, NW WASHINGTON, DC 20012
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(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 26  shower. At the time of the investigation, the GHIID staff failed to ensure Resident #2 received a shower in accordance with his rights.	I 500		