

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

PRINTED: 11/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018	
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W 000	<p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from November 6, 2013 through November 8, 2013. A sample of two clients was selected from a population of three men with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.</p> <p>The findings of the survey were based on observations, interviews with one client, one client's mother, direct support staff, nursing and administrative staff, as well as a review of clients' medical and habilitation records and the facility's administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Day Program Staff - DPS Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHID Facility Coordinator - FC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN</p>	W 000	<p>The Governing Body of Innovative Life Solutions (ILS) has received deficiency report as cited during our annual licensure survey. ILS has implemented relevant systems and procedures to prevent and or minimize any reoccurrences from an agency standpoint and ensure compliance to regulatory codes highlighted in this survey process (on-going).</p> <p><i>Received DOH 12/5/13</i></p>	
W 125	<p><b>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States,</p>	W 125		

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

*Kimberly Walker*

TITLE

*VP of 10 services*

(X6) DATE

*12/5/13*

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 125	<p>Continued From page 1 including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the right of each client to receive timely assistance with managing personal funds, for one of two clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>I. On November 6, 2011, at approximately 8:15 a.m., Client #1 informed this surveyor that the television in his bedroom "does not work right." The client manually turned on the television and complained that his remote control did not work. He also complained that he could not receive sports channels. Client #1 further stated that "a man from the office" had told him he would "look into it" (date not indicated).</p> <p>On November 6, 2013, at 3:10 p.m., the facility's information technology technician (IT1) was observed working in another client's bedroom. When asked about Client #1's television, IT1 stated that he was aware that the client wanted sports channels. At one time, the client had satellite television service. IT1 further explained that when the satellite service was discontinued (date not indicated), the remote control stopped functioning. IT1 said he liked to see clients "have what they want" and would speak with the administrator about the situation.</p> <p>When interviewed on November 8, 2011, at 12:54 p.m., the facility coordinator (FC1) indicated that Client #1, who is an avid Redskins fan, began complaining about the lack of sports channels on</p>	W 125	<p>ILS ensured that Client #1 television, remote and all cable channels were installed and working properly (completed 12/2/13). All management staff will be in-serviced on the importance immediate follow up to individuals' concerns by 12/11/13.</p> <p>ILS will continue to follow up on all individuals' personal request and concerns to ensure they are addressed in a timely manner and to prevent further occurrences.</p>	
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W 125	Continued From page 2 his television when the football season approached (date not specified). A moment later, the QIDP indicated that it was "likely" Client #1 would get cable service (unknown time frame) and would "have to find out" if the client would pay for it.  II. On November 7, 2013, beginning at 2:29 p.m., review of Client #1's financial records revealed that his individual financial plan, dated February 12, 2013, allocated \$1020 in personal funds for massage services. At 2:41 p.m., when asked about massage services, Client #1 confirmed that he wanted massages. He further stated nobody had spoken with him about massages since his interdisciplinary team met in February 2013.  On November 8, 2013, at 12:56 p.m., interview with QIDP1 revealed that she was unaware of the Client #1's desire to get massages. [Note: She began providing QIDP services for this facility in May 2013.]  At the time of the survey, the facility failed to establish a system to ensure that clients consistently received timely assistance and support to exercise their right to spend funds on preferred items and activities, as indicated.	W 125	ILS will ensure a client check request for massage services is submitted and an actual date for service is established by 12/13/13.  In addition, ILS will ensure a team meeting is held to discuss Client #1 current financial plan and his ability to participate in monthly massage sessions by 12/18/13.  ILS will ensure that all management staff is in-serviced on the importance of follow up and implementation of Individual Financial Plans as written by 12/11/13.	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN  The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.  This STANDARD is not met as evidenced by:	W 227	ILS will continue to monitor all individuals records and programs through daily, weekly, monthly, quarterly and PRN audits to ensure compliance and to prevent further occurrences.	

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W 227	<p>Continued From page 3</p> <p>Based on observations, interviews and record review, the facility failed to ensure that each client's individual program plan (IPP) stated specific objectives necessary to meet each client's needs, for two of two clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <p>[Cross-refer to W252 and W371]</p> <p>On November 6, 2013, observation of the morning medication administration followed by review of Client #1's and #2's MARs revealed that nursing staff were documenting daily performance data for self-medication training programs. Clients #1 program reflected the following objective: "Given verbal cues, &lt;Client #1's name&gt; will assist nurse with punching out and taking his own medication and writing his initials on the MAR." Clients #2's included: "Given verbal cues, &lt;Client #2's name&gt; will assist nurse with punching out and taking his own medication." Both clients' programs outlined the frequency (daily), the methodology and specific tasks to be achieved.</p> <p>Review of Client #1's and #2's IPPs, however, on November 7, 2013 (12:20 p.m.) and November 8, 2013 (11:40 a.m.) respectively revealed the self-medication training programs were not incorporated into either of the clients' IPPs.</p> <p>When interviewed on November 8, 2013, at 1:04 p.m., the QIDP (QIDP1) stated that Client #1's and #2's interdisciplinary teams had recommended they have self-medication training programs. When further queried, she said the nursing team developed and implemented the programs, then acknowledged that those</p>	W 227	<p>ILS ensured the LPN was retrained on the Medication Administration Policy, on ILS Nursing Department Expectations for Medication Nurse, and on the individuals' self-medication programs. Additionally the LPN received documented coaching regarding performing and documenting self-medication programs (see attached).</p>	
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W 227	Continued From page 4 programs were not incorporated in either client's IPP.	W 227		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure that each client's self-medication training program was implemented consistently, for two of two clients in the sample. (Clients #1 and #2)  The findings include:  On November 6, 2013, observation of the morning medication administration revealed the following:  1. At 7:39 a.m., the medication nurse (LPN1) punched Client #2's medications into a medication cup and handed the cup to the client. LPN1 instructed the client to pick-up his glass of water. Client #2 consumed his medications and after receiving repeated verbal encouragement from LPN1, he drank his water and then left the nurse station carrying the empty beverage glass.  On November 6, 2013, at 3:25 p.m., review of	W 249	ILS ensured the LPN was retrained on the Medication Administration Policy, on ILS Nursing Department Expectations for Medication Nurse, and on the individuals' self-medication programs. Additionally the LPN received documented coaching regarding performing and documenting self-medication programs (see attached).	

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W 249	<p>Continued From page 5</p> <p>Clients #2's MAR revealed that he had a self-medication training program. The program included: "Given verbal cues, &lt;Client #2's name&gt; will assist nurse with punching out and taking his own medication." The tasks outlined included:</p> <ul style="list-style-type: none"> <li>- Retrieve water;</li> <li>- Punch medication;</li> <li>- Take medication; and</li> <li>- Apply topicals.</li> </ul> <p>Observations on the morning of November 6, 2013 revealed that LPN1 did not provide Client #2 the opportunity to assist with punching his medications out of the blister packs, in accordance with the training program.</p> <p>II. At 7:52 a.m., LPN1 punched Client #1's medications into a medication cup and carried the medications upstairs to the client's bedroom. At 8:04 a.m., LPN1 reviewed each of the medications with him, handed the medication cup to the client and he consumed them. He immediately picked-up a glass of water and drank from it. LPN1 returned to the nurses office in the basement and initialed the client's MARs.</p> <p>On November 6, 2013, at 1:54 p.m., review of Clients #1's MAR revealed that he had a self-medication training program. The program included: "Given verbal cues, &lt;Client #1's name&gt; will assist nurse with punching out and taking his own medication and writing his initials on the MAR." The tasks outlined included:</p> <ul style="list-style-type: none"> <li>- Identify Medication</li> </ul>	W 249	<p>All staff to include Quality Compliance, Program Director, QIDP, FC, Supervising RN and LPN will receive in-service Training on the importance of following up on recommendations and ensuring all individuals programs are being implemented accordingly by 12/11/13.</p> <p>ILS will continue to monitor all individuals records and programs through daily, weekly, monthly, quarterly and PRN audits to ensure compliance and to prevent further occurrences.</p>	
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W 249	Continued From page 6  - Retrieve water;  - Punch medication;  - Take medication; and  - Initial MAR.  Observations on the morning of November 6, 2013 revealed that LPN1 did not provide Client #1 the opportunity to assist with punching his medications out of the blister packs or initialing his MAR, in accordance with the training program.  On November 8, 2013, at 1:05 p.m., the RN (RN1) presented documentation showing that LPN1 had received training on the two clients' self-medication training programs on October 30, 2013. Observations on November 6, 2013, however, revealed LPN1 did not consistently provide opportunities for the clients to develop and maintain their skills.	W 249			
W 252	483.440(e)(1) PROGRAM DOCUMENTATION  Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure program documentation was consistently collected and accurate, for two of two clients in the sample.	W 252	ILS ensured the LPN was retrained on the Medication Administration Policy, on ILS Nursing Department Expectations for Medication Nurse, and on the individuals' self-medication programs. Additionally the LPN received documented coaching regarding performing and documenting self-medication programs (see attached).		

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W 252	<p>Continued From page 7 (Clients #1 and #2)</p> <p>The findings include:</p> <p>[Cross-refer to W371]</p> <p>The facility failed to ensure that medication nurses accurately documented clients' skills/ performance during the medication administration. On November 6, 2013, observation of the morning medication administration revealed the following:</p> <p>I. At 7:39 a.m., the morning medication nurse (LPN1) punched Client #2's medications into a medication cup and handed the cup to the client. Client #2 consumed his medications, drank his water and then left the nurse station.</p> <p>On November 6, 2013, at 3:25 p.m., review of Clients #2's MARs revealed a data collection sheet on which medication nurses had been documenting the client's performance with a self-medication training program. Review of said training program revealed the following: "Given verbal cues, &lt;Client #2's name&gt; will assist nurse with punching out and taking his own medication." LPN1 documented that the client had punched his medications from the blister packs with verbal prompts. The documentation differed from what was observed during the medication administration process eight hours earlier.</p> <p>II. At 7:52 a.m., LPN1 punched Client #1's medications into a medication cup and carried them upstairs to the client's bedroom. At 8:05 a.m., LPN1 handed the medication cup to the client and he consumed them, followed by a drink of water. The nurse returned to the nursing office in the basement and initialed the client's MARs.</p>	W 252	<p>All staff to include Quality Compliance, Program Director, QIDP, FC, Supervising RN and LPN will receive in-service Training on the importance of following up on recommendations and ensuring all individuals programs are being implemented accordingly by 12/11/13.</p> <p>ILS will continue to monitor all individuals records and programs through daily, weekly, monthly, quarterly and PRN audits to ensure compliance and to prevent further occurrences.</p>	
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W 252	Continued From page 8  On November 6, 2013, at 1:54 p.m., review of Clients #1's MARs revealed a data collection sheet on which medication nurses had been documenting the client's performance with a self-medication training program. Review of said training program revealed the following: "Given verbal cues, <Client #1's name> will assist nurse with punching out and taking his own medication and writing his initials on the MAR." LPN1 documented that the client had punched his medications from the blister packs with verbal prompts. The documentation differed from what was observed during the medication administration process eight hours earlier. [Note: LPN1 did not record any data for the task of initialing his MAR.] LPN1 was not observed in the facility during the remainder of the survey.	W 252		
W 339	483.460(c)(4) NURSING SERVICES  Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to establish and implement a system to ensure each client's personal hygiene, self-care and the maintenance of skin integrity, for one of two	W 339	All staff was retrained on reminding individual to use restroom in time frame recommended and on hygiene care (completed 11/8/13). A form was created for staff to officially document the reminders. The individual was also retrained on his hygiene care (see attachments).	

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W 339	<p>Continued From page 9 clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>I. The facility failed to implement Client #1's POS to encourage the client to void every 3 hours, as follows:</p> <p>A medication nurse (LPN1) was observed administering Client #1's medications and treatments on the morning of November 6, 2013. At approximately 7:57 a.m., she asked the client to remove his adult protective undergarment (apu) so she could treat a decubitus ulcer located on his right buttock. The apu was observed to be wet with yellow urine. She cleansed the wound with saline solution then applied triple antibiotic ointment before covering the wound with gauze.</p> <p>On November 6, 2013, beginning at 1:54 p.m., review of Client #1's POS, dated October 1, 2013, ("valid for 120 days") verified the treatment with saline solution, triple antibiotic ointment and gauze, as ordered. However, continued review of the POS revealed the following: "Encourage to void every 3 hours whether urges or not and staff to document on daily basis." The order, dated August 8, 2013, followed assessment by a urologist on August 7, 2013, and the concurrent development of an infected abscess on the client's right buttock. Subsequent review of Client #1's medical records did not show evidence of written daily documentation regarding voiding.</p> <p>Client #1 had been observed in the facility on November 6, 2013, from 6:36 a.m. - 8:54 a.m. and 4:44 p.m. - 6:59 p.m. The client was observed at day program on November 6, 2013, from 10:48 a.m. - 11:31 a.m. During those</p>	W 339	<p>All staff to include Quality Compliance, Program Director, QIDP, FC, Supervising RN and LPN will receive in-service Training on the importance of following up on recommendations and ensuring all individuals programs are being implemented accordingly by 12/11/13.</p> <p>ILS will continue to monitor all individuals records and programs through daily, weekly, monthly, quarterly and PRN audits to ensure compliance and to prevent further occurrences.</p>		

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W 339	<p>Continued From page 10</p> <p>periods, staff was not observed to encourage him to void.</p> <p>On November 7, 2013, at approximately 2:50 p.m., Client #1 was interviewed about his voiding habits and the use of apu's. He stated that he "sometimes" sat on the toilet but he did not do so on a routine basis. A direct support staff who worked with Client #1 on weekday evenings (DSP1) was present at the time of the interview. When asked, DSP1 stated that he and other staff periodically "check to see if he is wet" and they would have the client change his apu if needed. DSP1 further stated that Client #1 was not routinely asked to void.</p> <p>When interviewed on November 7, 2013, at 3:13 p.m., the QIDP (QIDP1) stated "there is no set schedule. Staff will ask if he needs to go or if he is wet... &lt;the client&gt; likes his privacy. For the most part, he will refuse" to use the toilet. When asked about documentation, QIDP1 stated that staff had not been instructed to document if/when he voided.</p> <p>On November 7, 2013, at approximately 11:15 a.m., review of staff in-service training records revealed nurses provided training on personal hygiene and skin integrity on May 14, 2013, August 20, 2013 and on September 25, 2013. There was no evidence, however, that the order for voiding "every 3 hours whether urges or not" was being implemented.</p> <p>II. Facility nurses did not consistently encourage Client #1 to keep his private areas clean and dry to promote healthy skin integrity, as follows:</p> <p>As noted above, Client #1 was wearing a wet apu</p>	W 339			

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

PRINTED: 11/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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W 339	<p>Continued From page 11</p> <p>on November 6, 2013, at approximately 7:58 a.m. When LPN1 observed the apu was wet, she verbally instructed the client to apply a new, dry apu. LPN1 did not, however, instruct him to wash and dry his private areas prior to securing the clean apu.</p> <p>On November 7, 2013, at 12:15 p.m., review of Client #1's urology assessment dated August 7, 2013, revealed the following: "...scrotal wall excoriation...change diaper often... keep scrotum clean/ good genital hygiene..." Review of the client's health management care plan (HMCP) revealed that nurses updated the HMCP on August 14, 2014 to reflect the urologist's findings and recommendations. The HMCP read: "Keep skin clean and dry. Encourage voiding at least every 2 hours to prevent accidental incontinence. Monitor skin during hygiene and encourage him to wash buttocks and private area with soap and water, dry thoroughly with towel..."</p> <p>When interviewed on November 7, 2013, at approximately 2:50 p.m., Client #1 stated that he "sometimes" washed with soap and water after he wet his apu. A moment later, DSP1 shared the same information. On November 8, 2013, at 1:00 p.m., RN1 stated that the client should be encouraged to wash and dry himself when he is wet.</p> <p>At the time of the survey, there was no evidence that facility staff ensured that Client #1's private area was kept clean and dry, in accordance with his medical plan. It should be noted that physician and nurse progress notes documented that Client #1's wound had been improving and healing since the infection developed in August 2013.</p>	W 339		
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W 472 W 472	Continued From page 12 483.480(b)(2)(i) MEAL SERVICES  Food must be served in appropriate quantity.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food portions were served in the appropriate quantity, for one of two clients in the sample. (Client #2)  The finding includes:  On November 6, 2013, at 11:40 a.m., observation of Client #2's lunch revealed that he brought a lunch that was prepared at home. His lunch consisted of a tuna salad sandwich, crackers with peanut butter, juice and a banana. There was no vegetable observed. A day program direct support staff (DPS1) replied "sometimes" when asked if Client #2 brought vegetables in his bagged lunches.  On November 6, 2013, at 1:25 p.m., review of Client #2's diet orders revealed he was prescribed an 1800 calorie, low fat, low cholesterol, high fiber diet, with chopped meat texture. According to the menu that was presented by the facility coordinator (FC1), Client #2's lunch should have also included a tossed salad with fat free dressing that day.  On November 8, 2013, at 2:10 p.m., the house manager stated that direct support staff on the morning shift routinely prepared the clients' lunches. She further stated that staff had been trained to follow the menu and provide appropriate food substitutions if needed. Lunch observations on November 6, 2013, however,	W 472 W 472	ILS will ensure that all staff is in-serviced on mealtime protocol, lunch meals, and meal substitutions by 12/6/13.  In addition, ILS management will receive an in-service on the importance of ensuring food is purchased according to the menus by 12/11/13.  To prevent further occurrences, ILS will ensure that all staff follow the menu as written and provide substitutions when needed to all individuals.		

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W 472	Continued From page 13 revealed that staff did not consistently present foods in accordance with the prepared menus.	W 472			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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R 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from November 6, 2013 through November 8, 2013. A sample of two residents was selected from a population of three men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews with one resident, one resident's mother, direct support staff, nursing and administrative staff, as well as a review of residents' medical and habilitation records and the facility's administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Day Program Staff - DPS Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID Facility Coordinator - FC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN</p>	R 000		

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

*Kimberly Walker*

TITLE

*VP of ID services*

(X6) DATE

*12/5/13*

Health Regulation & Licensing Administration

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**INNOVATIVE LIFE SOLUTIONS**

STREET ADDRESS, CITY, STATE, ZIP CODE  
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WASHINGTON, DC 20018**

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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from November 6, 2013 through November 8, 2013. A sample of two residents was selected from a population of three men with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations, interviews with one resident, one resident's mother, direct support staff, nursing and administrative staff, as well as a review of residents' medical and habilitation records and the facility's administrative records.</p> <p>Note: The below are abbreviations that may appear throughout the body of this report.</p> <p>Day Program Staff - DPS Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID Facility Coordinator - FC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Medication Administration Record - MAR Physician's Order - POS Qualified Intellectual Disabilities Professional - QIDP Registered Nurse - RN</p>	I 000	<p>The Governing Body of Innovative Life Solutions (ILS), has received deficiency report as cited during our annual licensure survey. ILS has implemented relevant systems and procedures to prevent and or minimize any reoccurrences from an agency standpoint and ensure compliance to regulatory codes highlighted in this survey process (on-going).</p>	
I 040	<p><b>3502.1 MEAL SERVICE / DINING AREAS</b></p> <p>Each GHMRP shall provide each resident with a nourishing, well-balanced diet.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with</p>	I 040		

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

*Kimberly Walker*

TITLE

*VP of ID services*

(X6) DATE

*12/5/13*

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I 040	<p>Continued From page 1</p> <p>intellectual disabilities (GHIID) failed to ensure each resident received well-balanced, nutritious meals, for one of two residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>The GHIID staff failed to ensure that Resident #2 received the appropriate amount of food for lunch, as follows:</p> <p>On November 6, 2013, at 11:40 a.m., observation of Resident #2's lunch revealed that he brought a lunch that was prepared at home. His lunch consisted of a tuna salad sandwich, crackers with peanut butter, juice and a banana. There was no vegetable observed. A day program direct support staff (DPS1) replied "sometimes" when asked if Resident #2 brought vegetables in his bagged lunches.</p> <p>On November 6, 2013, at 1:25 p.m., review of Resident #2's diet orders revealed he was prescribed an 1800 calorie, low fat, low cholesterol, high fiber diet, with chopped meat texture. According to the menu that was presented by the facility coordinator (FC1), Resident #2's lunch should have also included a tossed salad with fat free dressing that day.</p> <p>On November 8, 2013, at 2:10 p.m., the house manager stated that direct support staff on the morning shift routinely prepared the residents' lunches. She further stated that staff had been trained to follow the menu and provide appropriate food substitutions if needed. Lunch observations on November 6, 2013, however, revealed that staff did not consistently present foods in accordance with the prepared menus.</p>	I 040	<p>ILS will ensure that all staff is in-serviced on mealtime protocol, lunch meals, and meal substitutions by 12/6/13.</p> <p>In addition, ILS management will receive an in-service on the importance of ensuring food is purchased according to the menus by 12/11/13.</p> <p>To prevent further occurrences, ILS will ensure that all staff follow the menus as written and provide substitutions when needed to all individuals.</p>	

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I 180	Continued From page 2	I 180		
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</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 ensure the right of each resident to receive timely assistance with managing personal funds, for one of two residents in the sample. (Resident #1)</p> <p>The findings include:</p> <p>I. On November 6, 2011, at approximately 8:15 a.m., Resident #1 informed this surveyor that the television in his bedroom "does not work right." The resident manually turned on the television and complained that his remote control did not work. He also complained that he could not receive sports channels. Resident #1 further stated that "a man from the office" had told him he would "look into it" (date not indicated).</p> <p>On November 6, 2013, at 3:10 p.m., the facility's information technology technician (IT #1) was observed working in another resident's bedroom. When asked about Resident #1's television, IT #1 stated that he was aware that the resident wanted sports channels. At one time, the resident had satellite television service. IT #1 further explained that when the satellite service was discontinued (date not indicated), the remote control stopped functioning. IT #1 said he liked to see residents "have what they want" and would speak with the administrator about the situation.</p>	I 180	<p>ILS ensured that Client #1 television, remote and all cable channels were installed and working properly (completed 12/2/13).</p> <p>All management staff will be in-serviced on the importance of immediate follow up to individuals' concerns by 12/11/13.</p> <p>ILS will continue to follow up on all individuals' personal request and concerns to ensure they are addressed in a timely manner and to prevent further occurrences.</p>	

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I 180	<p>Continued From page 3</p> <p>When interviewed on November 8, 2011, at 12:54 p.m., the house manager (HM1) indicated that Resident #1, who is an avid Redskins fan, began complaining about the lack of sports channels on his television when the football season approached (date not specified). A moment later, the QIDP indicated that it was "likely" Resident #1 would get cable service (unknown time frame) and would "have to find out" if the resident would pay for it.</p> <p>II. On November 7, 2013, beginning at 2:29 p.m., review of Resident #1's financial records revealed that his individual financial plan, dated February 12, 2013, allocated \$1020 in personal funds for massage services. At 2:41 p.m., when asked about massage services, Resident #1 confirmed that he wanted massages. He further stated nobody had spoken with him about massages since his interdisciplinary team met in February 2013.</p> <p>On November 8, 2013, at 12:56 p.m., interview with the QIDP revealed that she was unaware of the Resident #1's desire to get massages. [Note: She began providing QIDP services for this facility in May 2013.]</p> <p>At the time of the survey, the facility failed to ensure that residents' needs were met.</p>	I 180	<p>ILS will ensure a client check request for massage services is submitted and an actual date for service is established by 12/13/13. In addition, ILS will ensure a team meeting is held to discuss Client #1 current financial plan and his ability to participate in monthly massage sessions by 12/18/13.</p> <p>ILS will ensure that all management staff is in-serviced on the importance of follow up and implementation of Individual Financial Plans as written by 12/11/13.</p>	
I 500	<p>3523.1 RESIDENT'S RIGHTS</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>	I 500	<p>ILS will continue to monitor all individuals records and programs through daily, weekly, monthly, quarterly, and PRN audits to ensure compliance and to prevent further occurrences.</p>	

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I 500	<p>Continued From page 4</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 22 DCMR, Chapter 35 and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities), for two of two residents in the sample. (Resident #1)</p> <p>The findings include:</p> <p>I. [483.460(c)(4)] The GHIID failed to ensure Resident #1's right to receive treatment and care in accordance with his assessed needs, as follows:</p> <p>A. The facility failed to implement Resident #1's POS to encourage the resident to void every 3 hours, as follows:</p> <p>A medication nurse (LPN1) was observed administering Resident #1's medications and treatments on the morning of November 6, 2013. At approximately 7:57 a.m., she asked the resident to remove his adult protective undergarment (apu) so she could treat a decubitus ulcer located on his right buttock. The apu was observed to be wet with yellow urine. She cleansed the wound with saline solution then applied triple antibiotic ointment before covering the wound with gauze.</p> <p>On November 6, 2013, beginning at 1:54 p.m., review of Resident #1's POS, dated October 1, 2013, ("valid for 120 days") verified the treatment with saline solution, triple antibiotic ointment and</p>	I 500	<p>ILS ensured the LPN was retrained on the Medication Administration Policy, on ILS Nursing Department Expectations for Medication Nurse, and on the individuals' self-medication programs. Additionally, the LPN received documented coaching regarding performing and documenting self-medication programs (see attachments).</p>	

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I 500	<p>Continued From page 5</p> <p>gauze, as ordered. However, continued review of the POS revealed the following: "Encourage to void every 3 hours whether urges or not and staff to document on daily basis." The order, dated August 8, 2013, followed assessment by a urologist on August 7, 2013, and the concurrent development of an infected abscess on the resident's right buttock. Subsequent review of Resident #1's medical records did not show evidence of written daily documentation regarding voiding.</p> <p>Resident #1 had been observed in the facility on November 6, 2013, from 6:36 a.m. - 8:54 a.m. and 4:44 p.m. - 6:59 p.m. The resident was observed at day program on November 6, 2013, from 10:48 a.m. - 11:31 a.m. During those periods, staff was not observed to encourage him to void.</p> <p>On November 7, 2013, at approximately 2:50 p.m., Resident #1 was interviewed about his voiding habits and the use of apu's. He stated that he "sometimes" sat on the toilet but he did not do so on a routine basis. A direct support staff who worked with Resident #1 on weekday evenings (DSP1) was present at the time of the interview. When asked, DSP1 stated that he and other staff periodically "check to see if he is wet" and they would have the resident change his apu if needed. DSP1 further stated that Resident #1 was not routinely asked to void.</p> <p>When interviewed on November 7, 2013, at 3:13 p.m., the QIDP (QIDP1) stated "there is no set schedule. Staff will ask if he needs to go or if he is wet... &lt;the resident&gt; likes his privacy. For the most part, he will refuse" to use the toilet. When asked about documentation, QIDP1 stated that staff had not been instructed to document if/when</p>	I 500	<p>All staff was retrained on reminding individual to use restroom in time frame recommended and on hygiene care (completed 11/8/13). A form was created for staff to officially document the reminders.</p> <p>The individual was also retrained on his hygiene care.</p>	

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I 500	<p>Continued From page 6</p> <p>he voided.</p> <p>On November 7, 2013, at approximately 11:15 a.m., review of staff in-service training records revealed nurses provided training on personal hygiene and skin integrity on May 14, 2013, August 20, 2013 and on September 25, 2013. There was no evidence, however, that the order for voiding "every 3 hours whether urges or not" was being implemented.</p> <p>B. Facility nurses did not consistently encourage Resident #1 to keep his private areas clean and dry to promote healthy skin integrity, as follows:</p> <p>As noted above, Resident #1 was wearing a wet apu on November 6, 2013, at approximately 7:58 a.m. When LPN1 observed the apu was wet, she verbally instructed the resident to apply a new, dry apu. LPN1 did not, however, instruct him to wash and dry his private areas prior to securing the clean apu.</p> <p>On November 7, 2013, at 12:15 p.m., review of Resident #1's urology assessment dated August 7, 2013, revealed the following: "...scrotal wall excoriation...change diaper often... keep scrotum clean/ good genital hygiene..." Review of the resident's health management care plan (HMCP) revealed that nurses updated the HMCP on August 14, 2014 to reflect the urologist's findings and recommendations. The HMCP read: "Keep skin clean and dry. Encourage voiding at least every 2 hours to prevent accidental incontinence. Monitor skin during hygiene and encourage him to wash buttocks and private area with soap and water, dry thoroughly with towel...."</p> <p>When interviewed on November 7, 2013, at approximately 2:50 p.m., Resident #1 stated that</p>	I 500	<p>All staff to include Quality Compliance, Program Directors, QIDP, FC, Supervising RN and LPN will receive in-service training on the importance of following up on recommendations and ensuring all individuals programs are being implemented accordingly by 12/11/13.</p> <p>ILS will continue to monitor all individuals records and programs through daily, weekly, monthly, quarterly, and PRN audits to ensure compliance and to prevent further occurrences.</p>	

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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1 500	<p>Continued From page 7</p> <p>he "sometimes" washed with soap and water after he wet his apu. A moment later, DSP1 shared the same information. On November 8, 2013, at 1:00 p.m., RN1 stated that the resident should be encouraged to wash and dry himself when he is wet.</p> <p>At the time of the survey, there was no evidence that facility staff ensured that Resident #1's private area was kept clean and dry, in accordance with his medical plan. It should be noted that physician and nurse progress notes documented that Resident #1's wound had been improving and healing since the infection developed in August 2013.</p> <p>II. [483.480(b)(2)(i)] The GHIID failed to ensure that Resident #2's food portions were served in the appropriate quantity, as follows:</p> <p>On November 6, 2013, at 11:40 a.m., observation of Resident #2's lunch revealed that he brought a lunch that was prepared at home. His lunch consisted of a tuna salad sandwich, crackers with peanut butter, juice and a banana. There was no vegetable observed. A day program direct support staff (DPS1) replied "sometimes" when asked if Resident #2 brought vegetables in his bagged lunches.</p> <p>On November 6, 2013, at 1:25 p.m., review of Resident #2's diet orders revealed he was prescribed an 1800 calorie, low fat, low cholesterol, high fiber diet, with chopped meat texture. According to the menu that was presented by the facility coordinator (FC1), Resident #2's lunch should have also included a tossed salad with fat free dressing that day.</p> <p>On November 8, 2013, at 2:10 p.m., the house</p>	1 500		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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1500	<p>Continued From page 8</p> <p>manager stated that direct support staff on the morning shift routinely prepared the residents' lunches. She further stated that staff had been trained to to follow the menu and provide appropriate food substitutions if needed. Lunch observations on November 6, 2013, however, revealed that staff did not consistently present foods in accordance with the prepared menus.</p> <p>III. [Cross-refer to I180] The GHIID failed to ensure Resident #1's right to receive timely assistance with managing personal funds, as follows:</p> <p>A. On November 6, 2011, at approximately 8:15 a.m., Client #1 complained that the television in his bedroom "does not work right" and that his remote control did not work.</p> <p>When interviewed on November 8, 2011, at 12:54 p.m., the facility coordinator (FC1) indicated that Client #1, who is an avid Redskins fan, began complaining about the lack of sports channels on his television when the football season approached (date not specified). A moment later, the QIDP indicated that it was "likely" Client #1 would get cable service (unknown time frame) and would "have to find out" if the client would pay for it.</p> <p>B. On November 7, 2013, beginning at 2:29 p.m., review of Client #1's financial records revealed that his individual financial plan, dated February 12, 2013, allocated \$1020 in personal funds for massage services. At 2:41 p.m., when asked about massage services, Client #1 confirmed that he wanted massages. He further stated nobody had spoken with him about massages since his interdisciplinary team met in February 2013.</p>	1500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0274	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2013
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NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 WALNUT STREET, NE WASHINGTON, DC 20018
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1 500	Continued From page 9  On November 8, 2013, at 12:56 p.m., interview with QIDP1 revealed that she was unaware of the Client #1's desire to get massages.	1 500		

DEPARTMENT OF HEALTH  
HEALTH REGULATION & LICENSING  
ADMINISTRATION

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Washington DC 20002  
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202-724-8800

CREMR  
Rev. 9/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Name of Facility: Innovative Life Solutions, Inc.		Street Address, City, State, ZIP Code: 3112 Walnut St. NE Washington, DC		Survey Date: 11/08/13	Follow-up Dates(s):
Regulation Citation	Statement of Deficiencies	Ref. No.	Plan of Correction	Completion Date	
4701.2	<p><u>Background Check Requirement</u></p> <p>Each facility...shall cause each prospective employee or contract worker who will have, or foreseeably may have direct patient, resident or client access, to undergo a criminal background check that shall reveal the criminal history, if any, in the District of Columbia and the fifty (50) states. Finger printing or live scan shall be performed in the District of Columbia utilizing the Metropolitan Police department (MPD) or a private agency. The criminal background check shall be performed, following finger printing or live scan, by the MPD and Federal Bureau of Investigation (FBI) in an FBI-approved environment. The results of the criminal background checks shall be forwarded to the Department of Health.</p>		<p>ILS HR department has ensured that all non-licensed Professionals, hired after December 1, 2012 completed the DOH Fingerprinting process as required.</p> <p>To prevent further occurrences, ILS will ensure all new hires are scheduled to go through the live fingerprinting process.</p> <p>In addition, ILS added the live fingerprinting process to our on-boarding process. (on-going)</p>	(On-going)	

*Roland Follett* 11/25/13  
Name of Inspector Date Issued

*Kimberly Walker* 12/5/13  
Facility Director/Designee Date

DEPARTMENT OF HEALTH  
HEALTH REGULATION & LICENSING  
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Based on review of personnel records and interview with management staff, it was determined that the facility failed to obtain a finger print or live scan timely, for two of four employees hired in 2013. (DSP1 and DSP2)

The findings include:

On November 7, 2013, beginning at 4:09 p.m., review of the personnel records revealed the facility had six direct support professionals (DSP) working directly with residents. Four DSPs had been hired in 2013. Of those four, there was no evidence that two DSPs had been finger printed for an FBI background check timely, as follows:

1. According to the application form, DSP1 applied for employment on January 4, 2013. There was no evidence of an FBI finger print or live scan performed at the time of hire. Telephone interview with the human resources director (HRD) on November 8, 2013, at 10:53 a.m., revealed that the facility had not obtained finger prints for applicants from January 1, 2013 - March 1, 2013. She explained that the issue was brought to their attention months later and on September 4, 2013, they sent DSP1 for FBI finger printing. The record showed that DSP1 began working with the residents on February 18, 2013.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

2. Similarly, DSP2's personnel record reflected a February 7, 2013 application date and a start date of February 18, 2013. According to documentation forwarded by the HRD, DSP2 sought FBI finger printing on September 4, 2013, over six months after DSP2 began working with the residents.

It should be noted that Chapter 47 was amended to require FBI finger printing, effective December 2012.