

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2009
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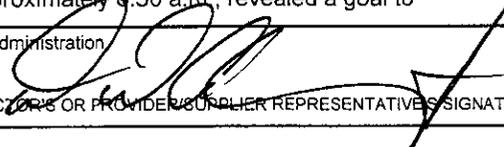
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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1 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from August 18, 2009 to August 20, 2009. A random sampling of three residents was selected from a population of five individuals with varying degrees of disabilities.</p> <p>The findings of this survey were based on observations at the group home and one day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.</p>	1 000	<p style="text-align: center;"><i>Received</i></p> <p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
1 230	<p>3510.5(g) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(g) Habilitation planning and implementation;</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure nursing staff were effectively trained in providing habilitation services for one of three residents in the sample. (Resident #4)</p> <p>The finding includes:</p> <p>During the medication pass observation on August 18, 2009 at approximately 7:35 a.m., Resident #4 was observed to punch out the medications on the correct date from the medication card and take the medications with one (1) verbal prompt.</p> <p>Review of Resident #4's Individual Program Plan (IPP) dated August 2009 on August 18, 2009 at approximately 8:30 a.m., revealed a goal to</p>	1 230	<p>I 230</p> <p>The administration acknowledges the need for # 4 to be on self medications programs. The Agency LPN received training on self medication and documentation from the RN on 9/25/09. The agency RN supervisor will be conducting quarterly review of # 4 and other individuals to ensure effective delivery of services as recommended. The RN will provide additional trainings to the LPN as needed.</p>	9/25/09

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LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE (X6) DATE

EXECUTIVE

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I 230	Continued From page 1 improve self medication skills. Further review revealed the following objectives "will punch out medication from the correct date and " will take her medications". Further review revealed Resident #4's level of participation was to be documented on the data collection sheet as follows (I) Independently; (V.R.) Verbal Reminders; (V.P.) Verbal Prompts; (G) Gestural Demonstration; (P.P.) Physical Prompts; (P.A.) Physical Assistance; (H.H.) Hand over Hand Assistance; (R) Refused; (O) Did not Participate; (A) Absent and (N) Done by Nurse. Review of the August, 2009, data on August 18, 2009 at approximately 8:45 a.m., revealed the nursing staff did not document Client #4's level of participation on August 17 and August 18, 2009. In an interview with the Registered Nurse (RN), on August 19, 2009, at approximately 8:45 a.m., it was acknowledged the nursing staff did not document Resident #4's level of participation on August 17 and August 18, 2009. There was no evidence the data had been collected in accordance with the IPP for Resident #4, which was necessary for a functional assessment of the resident's progress.	I 230		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by:	I 374	I 374 The administration acknowledges the importance of effective communication with #2 guardians at all times including event of an incident or when an individual requires additional medical care. The House Manager, LPN Coordinator, RN, QMRP received training on effective communication with #2 guardian and other circle of support members on 9/23/09. The Agency Incident management committee members meets weekly to discuss all incidents and recommendations accordingly, part of the committee responsibilities includes to ensure that all family members and guardian are notified of all incidents or other related matters in a timely manner. The training o effective communication with the RN, QMRP, LPN and the HM will continue every quarterly and as needed.	9/23/09

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1374	Continued From page 2 Based on interview and record review, the facility failed to notify guardians of all significant incidents, for one of the three residents in the sample. (Resident #2) The findings include: On August 18, 2009 beginning at 9:50 a.m., review of incident reports revealed that on June 6, 2009, Resident #2 was taken to an emergency room from a dialysis center due to nausea, vomiting and dizziness. Further review of the incident report revealed no evidence that the resident's guardian had been notified of the incident. Telephone interview with the guardian on August 20, 2009 beginning at 2:14 a.m. revealed that she had been appointed guardian prior to the resident's admission to this facility in December 2006. She informed the facility that she "wants to know if/when <resident's name> goes to an emergency room, within a reasonable amount of time." She reported having learned of the June 6, 2009 ER when she visited the resident in her home on June 26, 2009, almost 3 weeks after the event.	1374	Cross Reference PG 2	
1401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS 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. This Statute is not met as evidenced by: Based on interview and record verification, the	1401		

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I 401	Continued From page 3 facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with residents' needs, for two of the three residents in the sample. (Residents # 1 and #2) The findings include: 1. Interview with the Registered Nurse (RN) on August 18, 2009 at approximately 9:00 a.m., revealed Resident #2 was not administered Sensipar 30 mg, one tablet once a day for chronic kidney disease because the prior authorization form was not submitted to the pharmacist. Review of the July-August 2009, Medication Administration Records (MAR's) on August 18, 2009 at approximately 9:15 a.m., revealed Resident #2 was not administered Sensipar 30 mg daily from July 1, 2009 to August 18, 2009 because the prior authorization form was not submitted to the pharmacist. Further interview and review of the June, 2009, MAR revealed Resident #2 was not administered Sensipar 30 mg from June 3, 2009 to June 5, 2009, because the prior authorization form was not submitted to the pharmacist. Review of Resident #2's Medical Evaluation on August 18, 2009 at approximately 9:25 a.m., revealed diagnoses of diabetic nephropathy, renal insufficiency and secondary hyperparathyroidism. Further review revealed Resident #2 was receiving hemodialysis three (3) times a week. Review of the Primary Care Physician's (PCP's) order sheets on August 18, 2009 at approximately 9:30 a.m. dated June, July and August, 2009 revealed orders for Sensipar 30 mg, one tablet once a day. Review of nursing progress notes dated July 1-2, 2009, July 6, 2009, July 28, 2009 and August 12-13, 2009 on August 18, 2009 at approximately 10:35 a.m.	I 401	I401 The administration acknowledges the rights of all individuals to receive general care including medications as ordered, #2 was without Sensipar due to lack of insurance coverage. The LPN Coordinator attempted several measures to get Sensipar for #2. When Sensipar was first prescribed, one week supply was sent per physicians order, when it was reordered as a standing order, the pharmacy sent an incomplete month supply. The pharmacist notified the LPN that the physician would need to either switch the med to Roctoral or contact the insurance company. The nephrologists was notified immediately, she declined to switch to the Roctoral. She stated that she would address the matter with the insurance company. #2 PCP was also notified of the Nephrologists decision. In the future the agency medical team will get with the pharmacist and the prescribing doctor on a possible medication change with same effect. Additionally, the agency will contact the DDS case manager to ensure the proper medical care can be given.	08/19/09

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I 401	<p>Continued From page 4</p> <p>revealed the PCP and Nephrologist were made aware the pre-authorization for Sensipar 30 mg had not been submitted to the pharmacist and Resident #2 was not receiving the medication. Review of the pharmacist's Chronological Record of Drug Regimen Review dated July 6, 2009 on August 18, 2009 at approximately 10:40 a.m., revealed on May 26, 2009, prior authorization was needed for Sensipar 30 mg daily. Review of Client #2's Prescription Benefit Information document dated May 29, 2009, on August 18, 2009, at approximately 11:00 a.m. revealed that on May 27, 2009, a thirty (30) day supply of Sensipar 30 mg was dispensed by the pharmacy. Further review revealed the insurance company stated that they would not pay for an additional re-fill of Sensipar 30 mg unless the physician obtained a formulary exception from the insurance plan. Review of a Prescription Benefit Information document dated June 7, 2009, on August 18, 2009, at approximately 11:00 a.m. revealed that on June 5, 2009, a twenty-five (25) day supply of Sensipar 30 mg was given to filled for Resident #2. Further review revealed prior authorization for Sensipar 30 mg was required.</p> <p>There was no evidence that the preauthorization for Sensipar 30 mg was submitted to the pharmacist as required after June 7, 2009.</p> <p>2. Review of Resident #2's Medical Evaluation dated March 11, 2009, on August 18, 2009 at approximately 9:25 a.m., revealed diagnoses of diabetic nephropathy, renal insufficiency and secondary hyperparathyroidism. Review of Resident #2's medical record on August 19, 2009, at approximately 9:30 a.m., revealed a physician's order dated August, 2009, for a Complete Metabolic Panel (CMP),</p>	I 401	Cross Reference PG 4	

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I 401	<p>Continued From page 5</p> <p>calcium, hemoglobin diabetic control index (HgBA1C) and Complete Blood Count (CBC) laboratory studies performed quarterly. Review of Resident #2's medical records on August 18, 2009 at approximately 10:05 a.m., revealed the last documented laboratory studies for the aforementioned tests were dated April 8, 2009. In an interview with the RN on August 18, 2009 at approximately 10:15 a.m., it was acknowledged the CMP, calcium, HgBA1C and CBC laboratory studies had not been performed quarterly as recommended by the PCP.</p> <p>There was no evidence the routine laboratory testing was scheduled or obtained as recommended by the physician.</p> <p>3. There was no evidence the routine laboratory testing was scheduled or obtained as recommended by the physician, as follows:</p> <p>a. Review of Resident #2's medical record on August 19, 2009, at approximately 9:32 a.m., revealed a physician's order dated August, 2009, for phosphorous laboratory studies to be performed quarterly. Review of Resident #2's medical records on August 18, 2009 at approximately 10:06 a.m., revealed no documented evidence the phosphorous test was performed. In an interview with the RN August 19, 2009, at approximately 10:10 a.m., it was acknowledged phosphorous laboratory studies had not been performed quarterly as recommended by the PCP.</p> <p>b. Similarly, Resident #1's physician's orders as far back as August 2008 included orders to test serum levels of Depakene, Lipids and CBC every three months. On August 20, 2009 at 12:40 p.m., review of lab reports in her record revealed that</p>	I 401	<p>I 401</p> <p>The Administration acknowledges the importance of ensuring general and preventative care for all individuals including lab work as ordered by the physician. The administration also acknowledges that # 2 receives quarterly lab work at dialysis. The PCP has deemed the lab work drawn at dialysis to be a sufficient replacement of her previously ordered lab work and has stated that he does not want another set of labs drawn. The provider will ensure that this is reflected in updated lab orders as well as physician documentation by 10/1/09. The provider will ensure that each individuals lab orders are updated and completed as ordered. The RN will complete all trainings for the LPN Coordinators by</p>	

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1401	Continued From page 6 the three aforementioned lab values were obtained on January 14, 2009 and August 4, 2009, seven months apart.	1401		