

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

PRINTED: 10/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2011
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3250 'O' ST, SE WASHINGTON, DC 20020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from September 21, 2011 through September 23, 2011. A sample of three clients was selected from a population of six women with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with three clients, staff, in the home and three day programs, as well as a review of client and administrative records, including incident reports. [Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outside services met the needs of one of three clients in the sample. (Clients #1) The finding includes: Cross refer to W331. The facility failed to ensure that outside services met the needs of Client #1.	W 120		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

Approved 10/18/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

See W331

LABORATORY DIRECTORS OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 10/14/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the qualified intellectual disabilities professional (QIDP) failed to coordinate, monitor and integrate each client's active treatment, for six of six residents residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The findings include: 1. Cross refer to W120. Th QIDP failed to ensure outside services met the needs of Client #1. 2. Cross refer to W189. The QIDP failed to ensure that each staff were effectively trained on the facility's menus as recommended by the nutritionist. 3. Cross refer to W247. The QIDP failed to ensure to ensure client choice during meals, for six of six clients residing in the facility.	W 159			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 189	See W120 See W189 See W 247		

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W 189	Continued From page 2 review, the facility failed to ensure that each staff was effectively trained on the facility's menus as recommended by nutritionist, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The findings include: 1. The facility failed to ensure that food was served in the appropriate quantity for Client #1, #2, #3, #4, #5, and #6, as evidenced below: On September 21, 2011, beginning at 5:57 p.m., observations of the dinner meal revealed Staff #1 was observed to serve all clients' 4 small chicken wingettes, 1/2 cup of white rice, 1/2 cup of cabbage, and a beverage. At 6:34 p.m., interview with Staff #1 confirmed that all clients received the aforementioned food items for their dinner meal. On September 22, 2011, at approximately 4:21 p.m., review of the dinner menu for September 21, 2011, revealed the clients were to receive chicken wings, cabbage, rice, wheat bread, orange slices, margarine, and a beverage for dinner. Further review of the menu revealed the following: a. Client #1 was prescribed an 1800 calorie renal diet; b. Client #2 was prescribed a 1200 calorie diet; c. Client #3 was prescribed a 1500 calorie diet; d. Client #4 was prescribed a 1500 calorie diet; e. Client #5 was prescribed a low sodium, lactose free diet and; f. Client #6 was prescribed an 1800 calorie diet.	W 189	Nutritional inservice completed with staff. Training included how to read the menu according to the various calorie diets, appropriate portion sizes/quantity, drink and liquid allotment, A meal observation to be completed monthly by the QIDP or FC, to ensure meal time is followed according to each resident's diet.	10/13/11 11/1/11	

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W 189	<p>Continued From page 3</p> <p>Clients that were prescribed a 1200 and 1500 calorie diet were to receive 3 chicken wings and clients that were prescribed an 1800 calorie diet were to receive 4 chicken wings. In addition, the clients were to receive a slice of wheat bread. On September 22, 2011, at approximately 4:36 p.m., continued interview with Staff #1 who prepared the dinner on September 21, 2011, confirmed that the clients did not receive the correct portions of chicken as well as wheat bread in accordance with the prescribed menu. Staff #1 stated that she did not realize that the the amount of wingettes served to the clients' did not equal to the recommended amount on the dinner menu. She further stated that she totally forgot to served the clients their wheat bread.</p> <p>2. The facility failed to ensure that Client #2 received sugar free soda in accordance with the prescribed menu, as evidenced below:</p> <p>On September 21, 2011, at 6:00 p.m., Client #2 was observed to pour approximately 8-10 ounces of diet coke into her cup for dinner. Moments later, the client became upset when staff stated she could not have that much diet soda to drink for dinner. Client #2 was then given 4 ounces of diet soda with 8 ounces of water for dinner. Interview with the Staff #2 on the same day at approximately 6:02 p.m., revealed that according to the diet, Client #2 was to receive 4 oz of diet soda during dinner and the other 4 oz during snack time. Further interview with Staff #2 revealed that she had received training on the clients' diets and portion control.</p> <p>On September 22, 2011, at 4:21 p.m., review of the dinner menu for September 21, 2011,</p>	W 189		

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W 189	Continued From page 4 revealed that Client #2 should have 8 ounces of sugar free soda during dinner. Review of the in service training records on September 23, 2011, at approximately 2:00 p.m., revealed staff had received training on the menus and mealtime protocols on January 17, 2011, and August 4, 2011. There was no evidence that training had been effective.	W 189		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility staff failed to ensure client choice during meals, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The finding includes: On September 21, 2011, beginning at 5:57 p.m., observations of the dinner meal revealed Staff #1 was observed to place the following food items on the dining table: white rice, cabbage, baked wingettes, and a beverage. Staff #1 then served the clients their dinner. At 6:05 p.m., all clients were observed eating independently without the use of adaptive eating equipment. Between 6:05 p.m. and 6:31 p.m., Clients #1, #2, #3, #4, #5, and #6 were observed to take their plates/eating utensils to the kitchen sink, wash them using washing detergent, dry them, and placed them in the kitchen cabinets. Interview with the Staff #1 who prepared the meal	W 247		

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W 325	Continued From page 7 (LPN) on the same day at approximately 9:05 a.m. revealed that the depakote was prescribed for behaviors. Review of Client #2's medical records on September 22, 2011, at approximately 1:45 p.m., revealed a physician's order (PO's) dated September 2010. According to the PO's, Client #2's depakote levels were to be monitored every three months. Subsequent review of her medical records revealed there were no laboratory studies done until March 15, 2011, for the depakote (approximately six (6) months after the September 2010 POs). Interview with the facility's registered nurse (RN) and further record review on September 23, 2011, at 11:34 a.m., confirmed that laboratory studies for depakote were not completed every three months as prescribed.	W 325	
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 observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs of, one of three clients included in the sample. (Client #1) The findings include: 1. The facility's nursing staff failed to ensure a system was in place to track Client #1's fluid intake while at the day program, as evidenced	W 331	

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W 331	Continued From page 9 program, the QIDP responded by saying, we do not request the fluid intake forms from the day program. At the time of survey, there was no evidence that the facility was aware of the amount of fluids Client #1 received while at the day program. 2. Cross refer to W322. The facility's nursing staff failed to ensure Client 3's mammogram follow up appointment was scheduled within the recommended timeframe. 3. Cross refer to W325. The facility's nursing staff failed to ensure routine laboratory testing as determined necessary by the physician for Client #2.	W 331	See W322 See W325	
W 472	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 six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The findings include: Cross refer to W189. The qualified intellectual disabilities professional (QIDP) failed to ensure that staff were effectively trained to serve food in the appropriate quantity for six of six clients.	W 472	See W189	

Health Regulation & Licensing Administration

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1000	INITIAL COMMENTS A licensure survey was conducted from September 21, 2011 through September 23, 2011. A sample of three residents was selected from a population of six women with various intellectual and developmental disabilities. The findings of the survey were based on observations and interviews with three clients, staff, in the home and three day programs, as well as a review of resident and administrative records, including incident reports. [Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]	1000		
1042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that modified diets were served as prescribed, for six of six residents residing in the GHPID. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1. The GHPID failed to ensure that food was served in the appropriate quantity for Resident #1, #2, #3, #4, #5, and #6, as evidenced below:	1042		

Health Regulation & Licensing Administration

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

TITLE

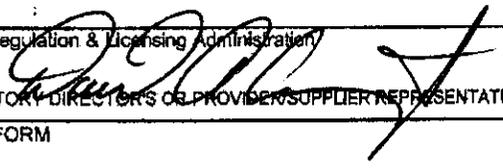
(X8) DATE

STATE FORM

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If continuation sheet 1 of 8



REGULATORY DIRECTOR

10/14/11

Health Regulation & Licensing Administration

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I 042	Continued From page 1 On September 21, 2011, beginning at 5:57 p.m., observations of the dinner meal revealed Staff #1 was observed to serve all residents' 4 small chicken wingettes, 1/2 cup of white rice, 1/2 cup of cabbage, and a beverage. At 6:34 p.m., interview with Staff #1 confirmed that all residents received the aforementioned food items for their dinner meal. On September 22, 2011, at approximately 4:21 p.m., review of the dinner menu for September 21, 2011, revealed the residents were to receive chicken wings, cabbage, rice, wheat bread, orange slices, margarine, and a beverage for dinner. Further review of the menu revealed the following: a. Resident #1 was prescribed an 1800 calorie renal diet; b. Resident #2 was prescribed a 1200 calorie diet; c. Resident #3 was prescribed a 1500 calorie diet; d. Resident #4 was prescribed a 1500 calorie diet; e. Resident #5 was prescribed a low sodium, lactose free diet and; f. Resident #6 was prescribed an 1800 calorie diet. Residents that were prescribed a 1200 and 1500 calorie diet were to receive 3 chicken wings and residents that were prescribed an 1800 calorie diet were to receive 4 chicken wings. In addition, the residents were to receive a slice of wheat bread. On September 22, 2011, at approximately 4:36 p.m., continued interview with Staff #1 who prepared the dinner on September 21, 2011, confirmed that the residents did not receive the correct portions of chicken as well as wheat	I 042	Nutritional inservice completed with staff. Training included how to read the menu according to the various calorie diets, appropriate portion sizes/quantity, drink and liquid allotments, A meal observation to be completed monthly by the QIDP or FC, to ensure meal time is followed according to each resident's diet.	10/12/11 11/1/11	

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I 042	Continued From page 2 bread in accordance with the prescribed menu. Staff #1 stated that she did not realize that the the amount of wingettes served to the residents' did not equal to the recommended amount on the dinner menu. She further stated that she totally forgot to served the residents their wheat bread. 2. The GHPID failed to ensure that Resident #2 received sugar free soda in accordance with the prescribed menu, as evidenced below: On September 21, 2011, at 6:00 p.m., Resident #2 was observed to pour approximately 8-10 ounces of diet coke into her cup for dinner. Moments later, the resident became upset when staff stated she could not have that much diet soda to drink for dinner. Resident #2 was then given 4 ounces of diet soda with 8 ounces of water for dinner. Interview with the Staff #2 on the same day at approximately 6:02 p.m., revealed that according to the diet, Resident #2 was to receive 4 oz of diet soda during dinner and the other 4 oz during snack time. Further interview with Staff #2 revealed that she had received training on the residents' diets and portion control. On September 22, 2011, at 4:21 p.m., review of the dinner menu for September 21, 2011, revealed that Resident #2 should have 8 ounces of sugar free soda during dinner. Review of the in service training records on September 23, 2011, at approximately 2:00 p.m., revealed staff had received training on the menus and mealtime protocols on January 17, 2011, and August 4, 2011. There was no evidence that training had been effective.	I 042			
I 180	3508.1 ADMINISTRATIVE SUPPORT	I 180			

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I 180	Continued From page 3 Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative support had been provided to effectively meet the needs, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1. Cross refer to federal citation W120. Th QIDP failed to ensure outside services met the needs of Resident #1. 2. Cross refer to federal citation W189. The QIDP failed to ensure that each staff were effectively trained on the GHPID's menus as recommended by the nutritionist. 3. Cross refer to federal citation W247. The QIDP failed to ensure to ensure resident choice during meals, for six of six residents residing in the GHPID.	I 180	 <u>See W120</u> <u>See W189</u> <u>See W247</u>	
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the training program agenda was maintained in the group home for persons with	I 223		

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I 223	Continued From page 4 intellectual disabilities (GHPID) and available for review by regulatory agencies for six of six residents residing in the GHPID. (Residents #1, #2, #3, #4, #5, and #6) The finding includes: On September 23, 2011, beginning at 10:34 a.m., review of the staff in-service training records revealed there were no agendas on file that described what topics/information had been covered during training's. (i.e. nutrition, rights, behavior management, sexuality, making choices, fluid restrictions, crisis protection interventions, fire drill, etc.) This was confirmed through interview with the clinical service director (CSD) on the same day at 10:57 a.m.	I 223	All inservices will include sign-in sheet, agenda and all materials covered. inservice with QIDP's and FC's completed on training inservices and what items are included for each inservice completed.	10/17/11 10/11/11
I 401	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 observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included 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 for two of three residents included in the sample. (Residents #1 and #2)	I 401		

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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		
(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 401	Continued From page 7 the primary care physician. On September 21, 2011, at approximately 9:02 a.m., observation of the morning medication administration pass revealed that Resident #2 was administered Divalproex DR (Depakote) 500 mg by mouth. Interview with licensed practical nurse (LPN) on the same day at approximately 9:05 a.m. revealed that the Depakote was prescribed for behaviors. Review of Resident #2's medical records on August 17, 2011, at approximately 1:45 p.m., revealed a physician's order (PO's) dated September 2010. According to the PO's, Resident #2's Depakote levels were to be monitored every three months. Subsequent review of her medical records revealed there were no laboratory studies done until March 15, 2011, for the Depakote (approximately six (6) months after the September 2010 POs). Interview with the GHPID's registered nurse (RN) and further record review on September 23, 2011, at 11:34 a.m., confirmed that laboratory studies for Depakote were not completed every three months as prescribed.	I 401		