

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

PRINTED: 10/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/26/2013
NAME OF PROVIDER OR SUPPLIER  INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7425 8TH STREET NW WASHINGTON, DC 20012	
(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 25, 2013 through September 26, 2013. A sample of two clients was selected from a population of three males with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process.  The findings of the survey were based on observations in the home and one day program, interviews with one parent, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.	W 000		
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, staff interview, and record verification, the facility failed to ensure that a client received their Baclofen as prescribed, for one of three client's in the sample. (Client #1)  The findings include:  On September 25, 2013, at approximately 3:05 p.m., the facility's supervisory registered nurse (RN, Staff #3) was informed that an observation of the medication pass would be conducted as a part of the survey process. The RN identified a licensed practical nurse (LPN, Staff #1) as the nurse that would administer the afternoon medications. At approximately 4:05 p.m., Staff #1 was observed at Client #1's bedside with a clear	W 368	W368 Innovative Life Solutions suspended "LPN, Staff #1", who did not follow ILS policy and procedure, nor the 6 Rights of Medication Administration, without pay, with recommendation made to HR for termination. (See Attached Letter of Suspension)  All nursing staff at the home were trained on the Medication Administration Policy (see attached training documentation and individually signed acknowledgement of required medication pass steps).  The Registered Nurse for the home performed medication observations for all nursing staff at the home after this event (see attached documentation of observations).  In the future, RN Supervision will ensure routine medication administration monitoring takes place at least semi-annually and as needed.  Additionally, the Director of Nursing's quarterly review of the home will include review of documentation that these observations are performed.	

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

TITLE

(X6) DATE

*Kimberly Welch*

*VP of ID Services*

*10/25/13*

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 368	<p>Continued From page 1</p> <p>plastic medication cup that held 2.5 milliliters (ml) of a pink liquid. Staff #1 administered the pink liquid to Client #1 via gastrointestinal tube (G-tube).</p> <p>On September 25, 2013, at approximately 4:15 p.m., an interview with Staff #1 revealed that the pink substance he administered to Client #1 was Baclofen. When asked to present the Baclofen bottle for verification, the nurse stated he had poured 2.5 ml from another client's (Client #3) bottle of Baclofen. The label on Client #3's bottle reflected: "Give 5 ml three times per daily via G-tube for muscle spasm Baclofen 5 mg/ml syrup." Staff #1 indicated that Client #1's empty bottle was in the trash.</p> <p>On September 26, 2013, at 10:00 a.m., a review of Client #1's physician's orders dated September 2013 revealed 2.5 ml of Baclofen 10 mg/5 ml to be given via G-tube at 4:00 p.m. On the prior afternoon, however, the client was observed being administered 2.5 ml of Baclofen 5 mg/ 5 ml, which was half the concentration ordered by the physician.</p>	W 368	<p>W369</p> <p>Innovative Life Solutions suspended "LPN, Staff #1", who did not follow ILS policy and procedure, nor the 6 Rights of Medication Administration, without pay, with recommendation made to HR for termination. (See Attached Letter of Suspension)</p> <p>All nursing staff at the home were trained on the Medication Administration Policy (see attached training documentation and individually signed acknowledgement of required medication pass steps).</p> <p>The Registered Nurse for the home performed medication observations for all nursing staff at the home after this event (see attached documentation of observations).</p> <p>In the future, RN Supervision will ensure routine medication administration monitoring takes place at least semi-annually and as needed.</p> <p>Additionally, the Director of Nursing's quarterly review of the home will include review of documentation that these observations are performed.</p>	
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to ensure the each client's medications were administered without error, for one of three client's in the sample (Client #1)</p>	W 369		

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W 369	<p>Continued From page 2</p> <p>The finding includes:</p> <p>The facility nurses failed to administer Client #1's Baclofen (for muscle spasms) at the dose prescribed by his physician, as follows:</p> <p>Cross-refer to W368. On September 25, 2013, at approximately 4:05 p.m., a licensed practical nurse (LPN, Staff #1) was observed administering 2.5 milliliters (ml) of Baclofen to Client #1 via G-tube. Moments later, Staff #1 stated he had poured the 2.5 ml from Client #3's bottle of Baclofen because Client #1's Baclofen supply was unavailable.</p> <p>On September 26, 2013, at 10:00 a.m., review of Client #1's physician's orders for September 2013, revealed that the client was to receive 2.5 ml of Baclofen 10 milligrams/ 5 ml via G-tube at 4:00 p.m. The label on the bottle from which the Baclofen was poured on the previous afternoon (belonging to Client #3) indicated it was 5 milligrams / 5 ml, half the concentration ordered by Client #1's physician.</p>	W 369		
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/26/2013
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1000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from September 25, 2013 through September 26, 2013. A sample of two residents was selected from a population of three males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with one parent, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p>	1000	<p>1481</p> <p>Innovative Life Solutions suspended "LPN, Staff #1", who did not follow ILS policy and procedure, nor the 6 Rights of Medication Administration, without pay, with recommendation made to HR for termination. (See Attached Letter of Suspension)</p> <p>All nursing staff at the home were trained on the Medication Administration Policy (see attached training documentation and individually signed acknowledgement of required medication pass steps).</p>	
1481	<p><b>3522.8 MEDICATIONS</b></p> <p>Each medication shall be stored in its original container and shall not be transferred to another container or taken or used by another person.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to ensure that each resident's medications was only given to the prescribed resident for one of three resident's in the sample (Resident #1)</p> <p>The finding includes:</p> <p>The facility nurses failed to only administer Resident #3's Baclofen (for muscle spasms) to the prescribed resident as ordered by his physician, as follows:</p> <p>Cross-refer to W368. On September 25, 2013, at approximately 4:05 p.m., a licensed practical nurse (LPN, Staff #1) was observed administering 2.5 milliliters (ml) of Baclofen to Resident #1 via G-tube. Moments later, Staff #1 stated he had poured the 2.5 ml from Resident #3's bottle of</p>	1481	<p>The Registered Nurse for the home performed medication observations for all nursing staff at the home after this event (see attached documentation of observations).</p> <p>In the future, RN Supervision will ensure routine medication administration monitoring takes place at least semi-annually and as needed.</p> <p>Additionally, the Director of Nursing's quarterly review of the home will include review of documentation that these observations are performed.</p>	

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I 481	<p>Continued From page 1</p> <p>Baclofen because Resident #1's Baclofen supply was unavailable.</p> <p>On September 26, 2013, at 10:00 a.m., review of Resident #1's physician's orders for September 2013, revealed that the resident was to receive 2.5 ml of Baclofen 10 milligrams/ 5 ml via G-tube at 4:00 p.m. The label on the bottle from which the Baclofen was poured on the previous afternoon (belonging to Resident #3) indicated it was 5 milligrams / 5 ml, half the concentration ordered by Resident #1's physician.</p>	I 481		