

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

PRINTED: 12/21/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G240</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/12/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOLUTIONS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 WALNUT STREET, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p><b>INITIAL COMMENTS</b></p> <p>An initial certification survey was conducted on December 12, 2012. 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.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>The survey revealed the facility operated by Innovative Life Solutions is in substantial compliance with the requirements of 42 CFR 483, Subpart I, Requirements for Intermediate Care Facilities.</p> <p>No deficiencies were cited.</p>	W 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0274</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/12/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INNOVATIVE LIFE SOLUTIONS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3112 WALNUT STREET, NE WASHINGTON, DC 20018</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted on December 12, 2012. 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 at one day program, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p> <p>No deficiencies were cited.</p>	I 000		

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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