

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2013
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 EAST CAPITOL STREET, NE WASHINGTON, DC 20019		
(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>INITIAL COMMENTS</p> <p>On February 27, 2013, the Department on Disability Services (DDS) forwarded to the State Surveying Agency (SSA) the Evans' Class Court Monitoring Program Reports that alleged concerns related to client health, safety and welfare.</p> <p>Based on the concerns, the SSA's Intermediate Care Facilities Division (ICFD) initiated a monitoring visit on March 21, 2013, to determine the facility's compliance with Federal participation and local licensure requirements.</p> <p>The findings were based on observations at the group home, interviews with direct care staff, nursing staff and administrative staff. The findings were also based on the review of medical, habilitation, and administrative records, as well as a review of the facility's incident management reporting system. The monitoring visit revealed the following:</p> <p>Allegation #1- Health Management Care Plans (HMCPs) for Clients #1, #2, and #3 were not updated and implemented.</p> <p>Findings - The survey process is outcome oriented, and the HMCP review is not within the scope of the regulatory authority.</p> <p>Conclusion - This is not applicable to the survey process.</p> <p>Allegation #2 - Occupational Therapy recommendations were not implemented for Client #1 and #3.</p>	W 000			

Received 4/15/13
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

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

TITLE

(X6) DATE

Ernest J. Glover

4/15/13

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 000	<p>Continued From page 1</p> <p>Findings -There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #3 - The shower chair was inferior and did not meet the needs of Client #1.</p> <p>Finding -There was no evidence to substantiate the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #4 - Physical Therapist (PT) recommendations for Clients #1 and #3 to be repositioned at their day program every 2 hours were not implemented.</p> <p>Finding - There was no evidence to substantiate the allegation.</p> <p>Conclusion -Not substantiated</p> <p>Allegation #5 - Client #2 spends hours sitting in the wheelchair without repositioning.</p> <p>Finding - Client #2 was observed on several occasions during the monitoring visit repositioning herself in the wheelchair, and also staff was observed repositioning Client #2 in the bed.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #6 -The PT's recommendations for repairs and adjustments of Client #1's wheelchair were not completed.</p> <p>Finding - The durable medical equipment</p>	W 000		

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W 000	<p>Continued From page 2</p> <p>contractor was observed making repairs to Client #1's wheelchair during the monitoring visit. No deficiencies were cited.</p> <p>Conclusion - Partially substantiated.</p> <p>Allegation #7 - The PT's recommendation to contact the vendor for an evaluation of Client #1's air mattress overlay was not completed.</p> <p>Finding - There was not enough evidence to support the allegation, as the mattress was firm and in good condition.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation # 8 - Client #1's liquids were not thickened to a honey consistency as recommended.</p> <p>Finding - There was not enough evidence to support the allegation, as the texture of Client #1's liquids was consistent with the physician's order.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #9 - Client #3's feeding tube protocol/guidelines included the name of another individual.</p> <p>Finding - There was no evidence to support the allegation, as all G-Tube protocols were appropriately identified for each client.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #10 - Client #2 was not provided an</p>	W 000			

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W 000	<p>Continued From page 3</p> <p>IPAD as recommended to assist with communication.</p> <p>Finding - There was no evidence to support the allegation. The recommendation for the IPAD was not approved by the Inter-disciplinary team (IDT)</p> <p>Conclusion - Partially substantiated</p> <p>Allegation # 11 - Client #2's speech and language pathology assessment did not describe specific positioning for tube feeding.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #12 - Staff did not inform Client #1 of the food items during the meal.</p> <p>Findings - There was no evidence to support the allegation. Food that was offered during the mealtime was described to the client.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #13 - The psychologist's recommendation that Clients #1 and #3 have desensitization programs was not clarified.</p> <p>Finding - Interview with the qualified intellectual disabilities professional (QIDP) confirmed that a desensitization program was inadvertently included in Client #3's psychological recommendations. At the time of the survey, Clients #1 and #2 did not have desensitization</p>	W 000		
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W 000	<p>Continued From page 4 programs.</p> <p>Conclusion - Partially substantiated.</p> <p>Allegation #14 - Risk areas (constipation, dehydration, weight loss) identified in the clients' nutritional assessments were not monitored by the nursing staff.</p> <p>Findings - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #15 - The physician's recommendations that age appropriate health screening tests be updated for Clients #1, #2, and #3, were not timely implemented.</p> <p>Findings - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #16) Client #1's physician's order for "liberal fluid intake" was not defined.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion -Not substantiated.</p> <p>Allegation #17 - Client # 1's fluid intake was not tracked, recorded, analyzed, and acted upon by the nurses.</p> <p>Findings - There was no evidence to support the allegation.</p>	W 000		

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W 000	Continued From page 5 Conclusion - Not Substantiated. Allegation #18 - Client #1's 5.5 pound weight loss identified by the primary care physician was not addressed by the nurse. Finding - There was no evidence to support the allegation. There was evidence that the nursing staff addressed the weight loss and the physician recommended monitoring. Conclusion - Not substantiated. Allegation #19 - Client #1's stools were not consistently monitored and documented. Finding - There was no evidence to support the allegation. Conclusion - Not substantiated. Allegation #20 - Client #1's positioning after meals to prevent aspiration was not consistent throughout the medical record. Finding - There was no evidence to support the allegation. Conclusion - Not substantiated Allegation #21 - Client #3's dental needs were not met. Finding - There was no evidence to support the allegation. Conclusion - Not substantiated	W 000			

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W 331	<p>Allegation #22 - Medication was not consistently stored in accordance with the licensing regulation facility.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the nursing staff assessed for proper placement of the gastrostomy tube (G tube), for one of three clients who received enteral feedings. (Client #3) The finding includes: The facility failed to ensure nurses assessed for the proper placement of Client #3's G-tube prior to instilling water as evidenced below: On March 21, 2013, at approximately 8:00 a.m., Licensed Practical Nurse (LPN) #1 announced that she was going to flush Client #3's G tube. The nurse approached the client and exposed the tube. She pulled up 30 cubic centimeters (cc) of air into a syringe and pushed the air into the tube. The nurse then pulled back on the syringe to check for residual, none was noted. She proceeded to flush the tube with 240 milliliters (ml) of water. The client tolerated the procedure well. At no time during the procedure did the nurse use a stethoscope to listen for the sound of air in the stomach.</p>	W 331	<p>W 331 All nursing staff was in-serviced on the Policy and Procedure for GTube feeding. In the future all nursing staff will receive Training on GTube P&P – for placement, feeding and documentation and be monitored by the RN Supervisor at least on a quarterly basis to ensure competency and knowledge of the protocol. See attached – Gtube P&P and in-service Record.</p>	4/15/13	

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W 331	Continued From page 7 Interview with the Supervisory Registered Nurse (SRN) #1 on March 21, 2013, at 10:15 a.m. revealed that LPN #1 should have used her stethoscope to listen for air to ensure proper placement in accordance with the facility's procedures and in accordance with nursing standards. Interview with LPN #1 on March 22, 2013, at approximately 10:15 a.m., revealed that the surveyor's presence made her nervous and she forgot the step. It should be noted that once SRN #1 was made aware of the issue, she called LPN #1 back the facility and provided training on the procedure of caring for client's with G-tubes.	W 331			

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1000	<p>INITIAL COMMENTS</p> <p>On February 27, 2013, the Department on Disability Services (DDS) forwarded to the State Surveying Agency (SSA) the Evans' Class Court Monitoring Program Reports that alleged concerns related to resident health, safety and welfare.</p> <p>Based on the concerns, the SAA Intermediate Care Facilities Division (ICFD) initiated a monitoring visit on March 21, 2013, to determine the Group Home for Individuals with Intellectual Disability's (GHID's) compliance with Federal participation and local licensure requirements.</p> <p>The findings were based on observations at the group home, interviews with direct care staff, nursing staff and administrative staff. The findings were also based on the review of medical, habilitation, and administrative records, as well as a review of the GHID's incident management reporting system. The monitoring visit revealed the following:</p> <p>Allegation #1- Health Management Care Plans (HMCPs) for Residents #1, #2, and #3 were not updated and implemented.</p> <p>Findings - The survey process is outcome oriented, and the HMCP review is not within the scope of the regulatory authority.</p> <p>Conclusion - This is not applicable to the survey process.</p> <p>Allegation #2 - Occupational Therapy recommendations were not implemented for Resident #1 and #3.</p> <p>Findings - There was no evidence to support the</p>	1000		

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

Ernest J. Gloran

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1 000	<p>Continued From page 1 allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #3 - The shower chair was inferior and did not meet the needs of Resident #1.</p> <p>Finding -There was no evidence to substantiate the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #4 - Physical Therapist (PT) recommendations for Residents #1 and #3 to be repositioned at their day program every 2 hours were not implemented.</p> <p>Finding - There was no evidence to substantiate the allegation.</p> <p>Conclusion -Not substantiated</p> <p>Allegation #5 - Resident #2 spends hours sitting in the wheelchair without repositioning.</p> <p>Finding - Resident #2 was observed on several occasions during the monitoring visit repositioning herself in the wheelchair, and also staff was observed repositioning Resident #2 in the bed.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #6 -The PT's recommendations for repairs and adjustments of Resident #1's wheelchair were not completed.</p> <p>Finding - The durable medical equipment contractor was observed making repairs to Resident #1's wheelchair during the monitoring visit. No deficiencies were cited.</p>	1 000			

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1 000	Continued From page 2 Conclusion - Partially substantiated. Allegation #7 - The PT's recommendation to contact the vendor for an evaluation of Resident #1's air mattress overlay was not completed. Finding - There was not enough evidence to substantiate this allegation, as the mattress was firm and in good condition. Conclusion - Not substantiated. Allegation # 8 - Resident #1's liquids were not thickened to a honey consistency as recommended. Finding - There was not enough evidence to support the allegation, as the texture of Resident #1's liquids was consistent with the physician's order. Conclusion - Not substantiated. Allegation #9 - Resident #3's feeding tube protocol/guidelines included the name of another individual. Finding - There was no evidence to support the allegation, as all G-Tube protocols were appropriately identified for each resident. Conclusion - Not substantiated. Allegation #10 - Resident #2 was not provided an IPAD as recommended to assist with communication. Finding - There was no evidence to support the allegation. The recommendation for the IPAD	1 000			

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1000	<p>Continued From page 3</p> <p>was not approved by the inter-disciplinary team (IDT)</p> <p>Conclusion - Partially substantiated</p> <p>Allegation # 11 - Resident #2's speech and language pathology assessment did not describe specific positioning for tube feeding.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #12 - Staff did not inform Resident #1 of the food items during the meal.</p> <p>Findings - There was no evidence to support the allegation. Food that was offered during the mealtime was described to the resident.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #13 - The psychologist's recommendation that Residents #1 and #3 have desensitization programs was not clarified.</p> <p>Finding - Interview with the qualified intellectual disabilities professional (QIDP) confirmed that a desensitization program was inadvertently included in Resident #3's psychological recommendations. At the time of the survey, Residents #1 and #2 did not have desensitization programs.</p> <p>Conclusion - Partially substantiated.</p> <p>Allegation #14 - Risk areas (constipation, dehydration, weight loss) identified in the residents' nutritional assessments were not</p>	1000			

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1000	<p>Continued From page 4 monitored by the nursing staff.</p> <p>Findings - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #15 - The physician's recommendations that age appropriate health screening tests be updated for Residents #1, #2, and #3, were not timely implemented.</p> <p>Findings - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #16) Resident #1's physician's order for "liberal fluid intake" was not defined.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #17 - Resident #1's fluid intake was not tracked, recorded, analyzed, and acted upon by the nurses.</p> <p>Findings - There was no evidence to support the allegation.</p> <p>Conclusion - Not Substantiated.</p> <p>Allegation #18 - Resident #1's 5.5 pound weight loss identified by the primary care physician was not addressed by the nurse.</p> <p>Finding - There was no evidence to support the allegation. There was evidence that the nursing</p>	1000			

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1000	<p>Continued From page 5</p> <p>staff addressed the weight loss and the physician recommended monitoring.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #19 - Resident #1's stools were not consistently monitored and documented.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p> <p>Allegation #20 - Resident #1's positioning after meals to prevent aspiration was not consistent throughout the medical record.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated</p> <p>Allegation #21 - Resident #3's dental needs were not met.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated</p> <p>Allegation #22 - Medication was not consistently stored in accordance with the licensing regulation GH11D.</p> <p>Finding - There was no evidence to support the allegation.</p> <p>Conclusion - Not substantiated.</p>	1000			

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G238	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2013
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5000 EAST CAPITOL STREET, NE WASHINGTON, DC 20019		
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I 291	Continued From page 6	I 291			
I 291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure individuals who made an entry in the resident's record dated it and signed it, for two of the three residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>On March 21, 2013, at 5:50 p.m., LPN #3 was observed administering medication to Resident #1. To verify the medication pass observations, a review was conducted of Resident #1's medical record on March 24, 2013, at approximately 2:00 p.m. The record revealed an order, dated March 20, 2013, that indicated to "keep upright in wheel chair for at least 45 minutes after each meal to prevent aspiration." Further review of the order revealed it failed to include the identity of the person who gave the order, the identity of the nurse who transcribed it, and how the order was received (i.e. verbal or by telephone).</p> <p>Interview with supervisory registered nurse (SRN) #1 on March 25, 2013, at approximately 2:00 p.m., revealed that the process for transcribing orders was for the nurse to write the order, date it, and sign it. When presented with the aforementioned order, SRN #1 acknowledged the deficient practice.</p> <p>On March 21, 2013, at approximately 5:37 p.m. Resident #3 was observed receiving a bolus feeding of isosource 1.5 via gastrostomy tube. During the feeding, LPN #3 explained to the</p>	I 291	<p>I 291</p> <p>All nursing staff was in-serviced on Nursing Documentation and the Medication Administration P&P. In the future all nursing staff will receive training on Medication policy for transcribing physician's orders and nursing documentation at least annually. See attached – Medication Administration P&P and Nursing documentation</p>	4/15/13	

Health Regulation & Licensing Administration

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I 291	Continued From page 7 surveyor that the resident is fed four times a day. Review of the original January 2013 physician's order reflected that Resident #3 had been prescribed Jevity 1.5 five times per day. However, an unknown person drew a line through the word Jevity and wrote in Isosource, leaving the frequency at five times per day. It could not be determined who made the strike through and on what date. On March 22, 2013 at approximately 4:40 p.m., an interview with SRN #1 was held to ascertain the facility's protocol for correcting physician orders when they are printed incorrectly. SRN #1 revealed that the nurse who made the strike through on the January 2013 order should have drawn a line through the incorrect order, initialed it, and written the correct order. SRN #1 was presented with the physician's order dated January 2013 and acknowledge the deficient practice.	I 291			
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 individuals with intellectual disabilities (GHID) failed to develop and implement systems to monitor the effectiveness of prescribed health care interventions for one of the five residents. (Resident #3).	I 401			

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I 401	Continued From page 8 The finding includes: 1. The GHPID failed to ensure that the nursing staff assessed for proper placement of Resident#3's gastrostomy tube (G tube) prior to instilling water, as evidenced below: On March 21, 2013, at approximately 8:00 a.m., Licensed Practical Nurse (LPN) #1 announced that she was going to flush Resident#3's G tube. The nurse approached the resident and exposed the tube. She pulled up 30 cubic centimeters (cc) of air into a syringe and pushed the air into the tube. The nurse then pulled back on the syringe to check for residual, none was noted. She proceeded to flush the tube with 240 milliliters (ml) of water. The resident tolerated the procedure well. At no time during the procedure did the nurse use a stethoscope to listen for the sound of air in the stomach. Interview with the Supervisory Registered Nurse (SRN) #1 on March 21, 2013, at 10:15 a.m. revealed that LPN #1 should have used her stethoscope to listen for air to ensure proper placement in accordance with the GHID's procedures and in accordance with nursing standards. Interview with LPN #1 on March 22, 2013, at approximately 10:15 a.m., revealed that the surveyor's presence made her nervous and she forgot the step. It should be noted that once SRN #1 was made aware of the issue, she called LPN #1 back the GHID and provided training on the procedure of caring for residents with G-tubes.	I 401	I 401 All nursing staff was in-serviced on the Policy and Procedure for GTube feeding. In the future all nursing staff will receive Training on GTube P&P – for placement, feeding and documentation and be monitored by the RN Supervisor at least on a quarterly basis to ensure competency and knowledge of the protocol. See attached – Gtube P&P and in-service Record.	4/15/13	