Received 8/7/08

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G194		R 07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, 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}	INITIAL COMMENTS A follow up survey was conducted on July 10 and July 11, 2008 to determine if this facility had regain compliance with the federal conditions of participation requirements. The client population included three males and four female residents with varying degrees of mental retardation. This findings of this survey was verified through observations in the group home, interview with management and direct care staff, and record review. At the time of this follow up visit, this facility was found to be in substantial compliance.	{W 000}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL 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 observations, and interviews, the QMRP failed to ensure coordination of services and program monitoring for two of the three clients in the sample . The findings include: 1. On July 10 and July 11, 2008 a follow-up visit was conducted to determine whether the facility was actively involved in a search for an appropriate day placement for Client #3. Reportedly, client #3 was on bedrest to support the healing of a surgical wound on his buttock. Interview with the nurse on July 10, 2008 at approximatley 6:15 PM revealed that the client's wound had healed and they were providing maintenance care to his buttock area. Further	{W 159}		8/6/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: F Mustafa | TITLE: Program Manager | (X6) DATE: 8/6/08

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G194		R 07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, 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 159}	Continued From page 1 interview with the nurse confimed that the primary care physician released Client #3 to return to day activities. Additionally the nurse indicated that the only concern she had was that when a day placement is provided wound care training and a repositioning protocol will need to be implemented at the day program location. Interview with the Qualified Mental Retardation Professional (QMRP) on both days revealed that a day program referral had been made by the Develpmental Disablilities Services' (DDS) casemeneager. The QMRP provided copies of the day placement referrals, however the referrals were dated 4/14/08 and 5/9/08, both prior to the original survey. There was no documented evidence of attempts by the QMRP to follow-up on the day program referrals since 5/08. A contact was made with the DDS case manager. The surveyor was unsuccesssful to secure any updated information of any recent day program referrals for Client #3. 2. The QMRP failed to ensure that direct care staff were documenting program objective in the frequency outlined in Client #1's IPP. [See W252]	{W 159}	W159 Referrals were made to two day program on 4/14/08 and 5/9/08. Both day programs rejected client #3 acceptance to their day program due to medical issue. This issue was discussed at client #3 ISP meeting held on 8/1/08. The IDT team recommended that Client #3 can go to the day program three times weekly for three hours accompany by the home staff. UCP is willing to accept client #3 under this condition.	8/6/08
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, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G194		R 07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, 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 189	Continued From page 2 training that enables the employee to perform his or her duties effectively, efficiently and competently. The finding includes: The facility failed to provide the staff with effective training on documentation of each client's participation in their IPP program objectives. [See W252]	W 189	W189 Training on client #1 IPP goals was held on 7/18/08 (see attached). QMRP will provide IPP training on a monthly basis to ensure that employee perform their duties effectively, efficiently and competently.	8/6/08
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure the implementation of an effective system of documenting clients' program progress one of three sampled Clients. [Clients #1] The findings include: On July 11, 2008 at approximately 2:00 PM, interview with the QMRP and review of Client #1's Individual Program Plan (IPP) revealed the following program objectives: 1. Client #1 will participate in bathing herself 75% of the trials for six consecutive months. The frequency for participation and data collection were daily. 2. Client #1 will brush her teeth 50% of the trails	W 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G194		R 07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, 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 252	Continued From page 3 for six consecutive months. The frequency for participation and data collection were daily. 3. Client #1 will set the table during dinner 80% of the trails for six consecutive months. The frequency for participation and data collection were daily. daily. 4. Client #1 will participate in table top activities of her choice 75% of the trails for six consecutive months. The frequency for participation and data collection were three times a week. Interview with the QMRP revealed that the direct care were trained on 6/5/08 on the importance of documentation of each client's IPP program implementation. Review of Client #1's IPP program documentation revealed that the frequency criteria was not being followed by the direct care staff. Review of the program data collection since the the May 2008 survey, the direct care staff had not documented client #1's program participation on July 8th through 10th, 2008. Therefore the objectives could not be accurately measured.	W 252	W252 ILS has implemented a System whereby QMRP will review all IPP goals documentation mothly. Monthly training on IPP goals documentation is also been implemented.	8/6/08
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	{W 436}		

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G194		R 07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, 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 436}	Continued From page 4 Based on client interview, observation, direct care staff interview, and record review, the facility failed to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of recommended equipment. The findings include: Interview with the QMRP on July 11, 2008 at approximately 1:30 AM revealed that an adaptive bathing mitt with a soap pocket had not been purchased for Client #2. According to the QMRP, the Occupational Therapist will follow up with a detailed description and options where this item could be purchased.	{W 436}	W436 Client #2 bathing mitt with a soap pocket has been purchased. ILS will ensure that all recommended adaptive equipment are available in a timely manner.	8/6/08

PRINTED: 07/30/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 07/11/2008
NAME OF PROVIDER OR SUPPLIER INNOVATIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 114 DIVISION AVENUE, 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) COMPLETE DATE
{I 000}	INITIAL COMMENTS A follow up survey was conducted on July 10 and July 11, 2008 to determine if this facility abated deficiencies cited in the May 30, 2008 deficiency report. The client population included three males and four femlae residents with varying degrees of mental retardation. This findings of this survey was verified through observations in the group home, interview with management and direct care staff, and record review. At the time of this follow up visit, this facility was found to be in substantial compliance.	{I 000}		
{I 420}	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on client interview, observation, direct care staff interview, and record review, the facility failed to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of recommended equipment. The findings include: Interview with the QMRP on July 11, 2008 at approximately 1:30 AM revealed that an adaptive bathing mitt with a soap pocket had not been purchased for Client #2. According to the QMRP, the Occupational Therapist will follow up with a detailed description and options where this item could be purchased.	{I 420}	I 420 Client #2 bathing mitt with a soap pocket has been purchased. ILS will ensure that all recommended adaptive equipment are available in a timely manner.	8/6/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE