

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

PRINTED: 12/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G185	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from December 3, 2008 through December 5, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of two males and three females with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.</p>	W 000	<p><i>See W 331</i></p> <p><i>See W 436</i></p>	
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the governing body failed to exercise general policy and operating direction over the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to ensure that Client #1 received appropriate nursing care services in accordance with the health care services policies. [See W331] 2. The governing body failed to ensure that each client had access to their adaptive supports in accordance with the agency's policy. [See W436] 	W 104	<p>(STREET) ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE</p> <p><i>See W 331</i></p> <p><i>See W 436</i></p>	

GOVERNMENT OF THE DISTRICT OF COLUMBIA
 DEPARTMENT OF HEALTH
 HEALTH REGULATION ADMINISTRATION
 825 NORTH CAPITOL ST., N.E., 2ND FLOOR
 WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mette Horne</i>	TITLE <i>Vice President</i>	(X6) DATE <i>12/30/09</i>
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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 104	Continued From page 1	W 104		
W 140	3. The governing body failed to ensure that facility obtained CLIA certification. [See W393] 483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and the review of records, the facility failed to establish and maintain a system that ensured a complete and accurate accounting of clients' funds that were entrusted to the facility, for five of the five clients residing in the facility. (Client #1, #2, #3, #4 and #5) The findings include: The facility failed to ensure each client's personal finances were accurate in accordance with the agency financial accounting system. Review of Clients #1, #2, #3, #4, and #5 financial records conducted on December 4, 2008 at approximately 2:45 PM revealed the following: a. Client #1's personal account documentation reflected withdrawals of \$200.00 on June 13, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on December 4, 2008 at approximately 2:47 PM revealed that the receipts were unavailable. Additionally, he/she reported that the previous House Manager handled the clients' personal funds. At the time of the survey, there were no receipts available to justify the expenditure.	W 140	CLIA certification has been obtained see attached. All funds have been re-deposited into each clients account from the governing body. In the future QMRP will review accounts every quarter to ensure accountability. Where monies are missing provider shall reimburse.	12/8/08
				12/8/09

Interviewed on December 4, 2008 at

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W 140	<p>Continued From page 2</p> <p>b. Client #2's personal account documentation reflected a withdrawal of \$ 100.00 on 9/11/08. Interview with the QMRP on December 4, 2008 at approximately 2:55 PM revealed that the receipts were unavailable. At the time of the survey, there were no receipts available to justify the expenditure.</p> <p>c. Client #3's personal account documentation reflected withdrawals on 9/11/08 (\$100.00), 8/13/08 (\$200.00) and 2/6/08 (\$205.91), totaling \$505.91. Interview with the QMRP on December 4, 2008 at approximately 3:00 PM revealed that the receipts were unavailable. At the time of the survey, there were no receipts available to justify the expenditures.</p> <p>d. Client #4's personal account documentation reflected a withdrawal of \$ 200.00 on 6/13/08. Interview with the QMRP on December 4, 2008 at approximately 3:05 PM revealed that the receipts were unavailable. At the time of the survey, there were no receipts available to justify the expenditure.</p> <p>e. Client #5's personal account documentation reflected a withdrawal of \$ 100.00 on 9/11/08 and on 8/13/08 \$200.00 was withdrawn (totaling \$300.00). Interview with the QMRP on December 4, 2008 at approximately 3:10 PM revealed that the receipts were unavailable. At the time of the survey, there were no receipts available to justify the expenditures.</p>	W 140		
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit</p>	W 149		

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W 149	<p>Continued From page 3</p> <p>mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish and/or implement policies that ensured the client's health and safety, for one of the five clients that resided in the facility. (Client #5)</p> <p>The finding includes:</p> <p>The facility failed to ensure the implementation of its "Incident Management" policy as outlined.</p> <p>On December 3, 2008, at approximately 10:11 AM, interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's investigative report dated April 2, 2008 revealed the following:</p> <p>On March 20, 2008, a direct care staff reported to License Practical Nurse (LPN) #1 that Client #5 was observed with an "injury of unknown origin, or bruise" on the right arm.</p> <p>On March 23, 2008 (three days later), LPN #1 reported to LPN #2 that Client #5 was observed with an "injury of unknown origin, or bruise" on the right arm. Neither the direct care staff nor LPN #1 completed an unusual incident report on March 20, 2008. Continued review of the facility's incident report failed to provide evidence that the aforementioned injury was reported immediately to the administrator or to other officials in accordance with State law. [See W153]</p> <p>Further review of the internal investigation revealed that the IMC interviewed Client #5.</p>	W 149	<p>Provider established new protocols pursuant to HCLIA survey at 12th Street location. The incidents in question preceeded the change. Provider moving forward shall:</p> <ul style="list-style-type: none"> - Fax and call/leave message with HCLIA for each incident report generated. Staff have been re-trained on incident reporting. In addition staff that failed to timely report have been terminated. 	12/8/08

generated, state...

addition...

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W 148	Continued From page 4 According to the interview with Client #5, she identified LPN #1 as the person that allegedly hit her on the arm with a shoe. As a result of the interview, the IMC determined that the client's injury was allegedly inflicted by LPN #1. Interview with the QMRP on December 4, 2008 at 1:32 PM revealed that whenever an incident occurred either the QMRP or the House Manager (HM) was responsible for notifying the administrator (also the Registered Nurse). Review of the facility's "Incident Management" policy on December 4, 2008 at approximately 2:00 PM revealed that all serious reportable incidents required immediate notification to be made to the facility's Incident Management Coordinator (IMC) and administration. Further review of the policy revealed the following: "It is the responsibility of the staff who witness, discovers or is informed of an incident to complete an incident report." Additionally, the policy revealed that "all investigations shall be completed within five (5) working days of the incident." At the time of the survey, the facility failed to ensure its "Incident Management" policy was implemented as outlined.	W 148		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153	Again, a new IMH reporting protocol has been implemented. Because this incident was not reported for 3 days the five ^{day} time frame for investigations was subsequently delayed.	12/14/08

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W 153 Continued From page 5

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator or to other officials in accordance with State Law as required by DC regulation (22 DCMR Chapter 35 Section 3619.10), for one of the five clients residing in the facility. (Clients #5)

The finding includes:

Review of the facility's Investigative reports and interview with the Qualified Mental Retardation Professional (QMRP) on December 3, 2008 at 1:45 PM, revealed the facility failed to report timely injuries of unknown origin as evidenced below:

Review of the facility's internal investigation dated April 2, 2008, revealed that Client #5 was discovered with a bruise/injury of unknown origin on her right arm. Interview with the QMRP and further review of the investigation revealed an incident report was not immediately generated for the incident. Continued review of the investigation revealed that the administrator was not notified of the incident until March 24, 2008.

W 153

Remediating the timely reporting will remedy the timely review of the investigation by the administrator. The investigation was reviewed within 5 days of the filing of the incident report. Unfortunately the report was done 3 days later and intern so was the investigation.

W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility

W 156

reporting will remedy the investigation.

The report was done 3 days later and intern so was the investigation.

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W 156	Continued From page 6 failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident. The finding includes: The facility failed to ensure that results of the internal investigation was reported to the administrator within five (5) working days. [See W149]	W 156		
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, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen.	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.	W 189	See W184	

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W 189	<p>Continued From page 7</p> <p>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 training that enabled the employee to perform his or her duties effectively, efficiently and competently.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation on December 5, 2008 at approximately 10:30 AM, revealed that Client #3's adaptive wrist splint for her right hand was soiled. Interview with the Qualified Mental Retardation Professional (QMRP) and the Registered Nurse (RN) revealed that staff were trained on the proper cleaning and sanitizing of adaptive equipment used by the clients in September 2008. Review of the in-service training log confirmed that the direct care staff had been trained on September 8, 2008. This training was not effective. 2. On March 20, 2008 the direct care staff reported to License Practical Nurse (LPN) #1 that Client #5 was observed with an "injury of unknown origin, or bruise" on the right arm. Review of the internal investigation report initiated on March 24, 2008 was reviewed on December 3, 2008 at approximately 10:45 AM. According to the investigation report, on March 27, 2008 the Incident Management Coordinator (IMC) interviewed Client #5 and the client identified LPN #1 as the person who hit her on the arm with a shoe. <p>Further review of the investigative report revealed</p>	W 189	<p>Staff have been retrained. See attached documentation. Staff that were responsible but failed to complete duties of reporting have been terminated.</p>	12/18/08
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Staff that were responsible but failed to complete

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W 189	Continued From page 8 a recommendation that documented, "Staff is to be trained on documentation of incidents (Training scheduled for Tuesday April 8, 2008)". Review of the in-service training log however, failed to provide evidence that the staff were trained as recommended.	W 189		
W 331	483.480(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 staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of five clients residing in the facility. (Client #3) The findings include: 1. The facility's nursing staff failed to ensure that Client #3's right hand wrist splint was worn as prescribed in the current Physician's Orders as evidenced below. Observations conducted at the day program on December 3, 2008 at 12:40 PM revealed Client #3 was engaged in a table top activity (bingo) with four other peers. Client #3 was observed to turn the bingo wheel to mix up the numbers with her left hand with physical assistance from staff. Client #3's right hand was observed to be in a curled position. Additional observations at the group home from 4:21 PM to 6:00 PM revealed that Client #3's right hand remained in a curled position throughout the evening. Review of the Client #3's Physician's Orders (POs) dated November 2008, on December 4,	W 331	Physical Therapist has re-assessed client number 3. Staff have been trained on range of motion and use of wrist splint. MAR shall be amended to reflect the actual time that the client shall wear the splint. Physical Therapist	12/18/08

on range of motion and use of wrist splint. reflect the actual time that the client shall wear the splint.

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W 331	<p>Continued From page 9</p> <p>2008 at 10:26 AM revealed the Client #3 was to wear a right hand wrist splint eight (8) hours daily for right hand contractures. Interview with the Qualified Mental Retardation Professional (QMRP) on December 4, 2008 at approximately 10:30 AM revealed that she was uncertain as to what time of the day the splint should have been worn. Additional interview with the facility's Registered Nurse (RN) on the same day at 11:30 AM revealed that the splint should have been worn during the evening shift from 4:00 PM to 12:00 AM.</p> <p>Review of Client #3's Medication Administration Record (MAR) on December 5, 2008 at approximately 3:00 PM revealed that the LPN signed that Client #5 wore the adaptive support (hand splint) for the time period prescribed. According to the RN, she interviewed the LPN over the phone. The LPN stated that Client #3 wore the hand splint for a duration of 3 1/2 hours on December 3, 2008. The MAR however, did not accurately reflect the actual time the client wore the splint. At the time of the survey, there was no evidence that Client #3's right hand wrist splint was worn as prescribed in the POs.</p> <p>2. The facility's nursing staff failed to update Client #3's Health Management Care Plan (HMCP) as evidenced by:</p> <p>Review of Client #3's Health Management Care Plan (HMCP) dated November 11, 2008 on December 4, 2008 at approximately 10:40 AM revealed that the HMCP had not been updated to include Client #3's use of her adaptive wrist splint to control right hand contractures. Interview with the RN at approximately 11:31 AM acknowledged that she had not updated the HMCP in the</p>	W 331	<p>HMCP has been updated by RN.</p>	12/12/08
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Interviewed LPN
Management Care Plan
updated by RN

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W 331	Continued From page 10 muscular skeletal area to include the client's need for a right hand wrist splint.	W 331		
W 367	<p>483.460(k) DRUG ADMINISTRATION</p> <p>The facility must have an organized system for drug administration that identifies each drug up to the point of administration.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have an organized system for drug administration for Client #4.</p> <p>The finding includes:</p> <p>The facility failed to ensure that the agency was implementing a clear system for medication accountability.</p> <p>Observation of the medication pass on December 3, 2008 at approximately 6:20 PM revealed that Client #4 received Magnesium Oxide 800 mg. Interview with the nurse revealed that this medication was used as an antibiotic. Review of the bubble pack during the administration revealed that the pill coinciding with December 4, 2008 was used on December 3, 2008. Review of the corresponding MAR (December 2008) revealed that the system for medication monitoring was inaccurate.</p> <p>According to interview with the Registered Nurse (RN) on December 4, 2008 at approximately 11:00 AM, Client #4's physician orders for the magnesium oxide were written on a ten day cycle. Further interview with the RN revealed that the pharmacy was unable to package this medication on a ten day cycle. Reportedly, the agency would</p>	W 367	<p>Methodology pertaining to to cycle of medications has been remedied by pharmacy. Magnesium Oxide is currently being on a ten day cycle.</p>	12/18/08

used as an antibiotic. Review of

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1914 PERRY STREET, NE WASHINGTON, DC 20017
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(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 367	Continued From page 11 have to inform the pharmacy 3 days prior to the medication running out in order for the medication to be delivered on time and ensure the client would not miss a dosage. Review of the physician's order, on the same day, revealed a December 3, 2008 order was written by the physician for the Magnesium Oxide. Additionally, the LPN and the RN indicated the bubble pack that was used during the medication administration was an extra package which was not returned to the pharmacy from an earlier delivery. It should be further noted that the RN explained that the pharmacy was in the process of changing the method in which Client #4's medication would be packaged.	W 367		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of one clients who requires glucose testing, (Client #1). The finding includes: On December 3, 2008 at approximately 7:42 AM, observation of the medication pass revealed that the Licensed Practical Nurse (LPN) used the finger stick method to test the client's blood glucose level. Interview with the LPN revealed	W 393		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09Q185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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W 393	Continued From page 12 that Client #1 had a diagnosis of Diabetes Mellitus, Type II and was prescribed Glucophage 850 mg one tab twice a day. Further interview with the LPN revealed that blood glucose levels were to be taken, using a glucometer before breakfast and dinner. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:00 AM, revealed that the facility did not have the required certification to conduct blood glucose testing as identified by Part 493 of the Clinical Laboratory Improvement Act (CLIA). This is a repeat deficiency.	W 393	See W104	
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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. Head was prescribed Glucophage This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure necessary adaptive equipment was maintained in good repair for one of the three clients included in the sample. (Client #3) The finding includes: Review of the Client #1's Physician's Orders (POs) dated November 2008 was reviewed on December 4, 2008 at 10:26 AM. According to the POs, Client #3 was to wear a right hand wrist	W436	A new wrist split has been ordered. See W104	4/29/08
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W 436

other communications aids, braces,
by the

A new wrist split
been ordered

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 090185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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W 436	Continued From page 13 splint eight (8) hours daily for right hand contractures. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 10:28 AM revealed that Client #3's right hand wrist splint was in her bedroom. When the surveyors asked to see the right hand wrist splint, the QMRP retrieved the splint from Client #3's bedroom. The right hand wrist splint was observed to be soiled, cracked, and the cushion attached to the splint was torn. The plastic portion of the splint was observed with several teeth mark indentions. Additional interview with the QMRP and the facility's Registered Nurse (RN) at approximately 11:30 PM acknowledged that the right hand wrist splint needed to be replaced. At the time of the survey, the facility failed maintain Client #1's wrist splint in good repair.	W 436		
W 440	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on December 3, 2008 at 9:43 AM revealed the facility had three shifts of direct care personnel. The shifts were identified as the following:	W 440	1314 PERRY STREET, NE WASHINGTON, DC 20017 <i>Wholistic disputes these shifts. In fact, every DSP must work at least one week end pursuant to wholistic policy unless they are a 1:1 or Housekeeping. No one at our agency works</i>	12/19/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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W 440	<p>Continued From page 14</p> <p>Weekdays</p> <p>1st shift 8 AM - 4 PM 2nd shift 4 PM - 12 AM 3rd shift 12 AM - 8 AM</p> <p>Weekends</p> <p>1st shift 8 AM - 4 PM 2nd shift 4 PM - 12 AM 3rd shift 12 AM - 8 AM</p> <p>Review of the fire drill reports revealed that no fire drills were conducted for the weekday shift (8 AM - 4 PM) for the months of December 2007 to February 2008 and September 2008 to November 2008. Further review of the fire drills revealed that no drills were conducted for the weekend shift (4 PM - 12 AM) for the months of December 2007 to February 2008 and June 2008 to August 2008. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.</p>	W 440	<p>Monday - Fri 4-12 or 12-8 that serves in direct care. That is why are quarterly schedule reflect weekends 8-4. We are uncertain as to who identified these as our shift.</p> <p>It is our position that our shift are:</p> <p>8-4 4-12 12-8</p> <p>with NO differentiation regarding weekdays or weekends. We have conducted quarterly drills for the aforementioned shifts.</p> <p>Please bear in mind that we are 24 hour services. Attends, direct support staff working Monday thru Friday or solely on weekdays is impractical.</p>	12/18/08
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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1 000 INITIAL COMMENTS

A licensure survey was conducted from December 3, 2008 through December 5, 2008. A random sample of three residents was selected from a resident population of two males and three females with various disabilities.

The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.

1 080 3504.1 HOUSEKEEPING

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that the residence was maintained safe, clean, attractive and sanitary manner and free from an accumulation of dirt.

The findings include:

Internal

1. Client #1 and Client #4's closet door was off track.
2. The wall in the hallway on the main level was observed with scrape marks.

External

Client #1 & 4 closet door was off track has been fixed
infall in hallway has been painted
12/5/08

Health Regulation Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM

Matto Jhona

TITLE
Vice President

(X6) DATE
12/30/08

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2008
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1090 Continued From page 1

1. The storm door at the main entrance was observed open and was unable to close.
2. The gutters surrounding the facility were observed with leaves and debris.
3. There was trash, boxes, crates and other garbage next to the driveway. According to interview with the House Manager the garbage was be picked up later in the week.

1090

Storm door is now easy to open & close 12/15/08

Trash has been cleared

1135 3505.5 FIRE SAFETY

Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.

This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel.

The finding includes:

Interview with the Qualified Mental Retardation Professional (QMRP) on December 3, 2008 at 9:43 AM revealed the GHMRP had three shifts of direct care personnel. The shifts were identified as the following:

Weekdays

1st shift 8 AM - 4 PM
2nd shift 4 PM - 12 AM
3rd shift 12 AM - 8 AM

Weekends

1135

Bulk Trash has been picked up

seen 440 been cleared

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04		STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017	
(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)
1135	Continued From page 2 1st shift 8 AM - 4 PM 2nd shift 4 PM - 12 AM 3rd shift 12 AM - 8 AM Review of the fire drill reports revealed that no fire drills were conducted for the weekday shift (8 AM - 4 PM) for the months of December 2007 to February 2008 and September 2008 to November 2008. Further review of the fire drills revealed that no drills were conducted for the weekend shift (4 PM - 12 AM) for the months of December 2007 to February 2008 and June 2008 to August 2008. At the time of the survey, the GHMRP failed to provide evidence of fire drills conducted quarterly as required.	1135	
1379	3619.10 EMERGENCIES In addition to the reporting requirement in 3619.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to report to governmental officials within 24 hours in accordance with this regulatory requirement. The finding includes:	1379	SEE VISIT

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 FERRY STREET, NE WASHINGTON, DC 20017
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1379 Continued From page 3

The review of the facility's unusual incident management system and interview with the Qualified Mental Retardation Professional (QMRP) on December 3, 2008 at 10:30 AM, revealed the facility failed to timely notify the governmental agency of the following incident(s):

Review of the unusual incident reporting system on December 3, 2008 at approximately 10:00 AM revealed that on January 19, 2008, Client #1 was taken to the emergency room due to a change in mental status. Further review of the report revealed that Client #1 was admitted to the hospital for a period of seventeen days.

1379

PROVIDER'S PLAN OF CORRECTION

1386 3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS

Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:

(e) Nursing:

This Statute is not met as evidenced by: Based on staff interview and record review the GHMRP failed to ensure nursing services in accordance with the needs of one of three residents included in the sample. (Client #3)

The findings include:

1386

PROVIDER'S PLAN OF CORRECTION

See 1389

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1395 Continued From page 4

1. The GHMRP's nursing staff failed to ensure that Resident #3's right hand wrist splint was worn as prescribed in the current Physician's Orders as evidenced below:

Observations conducted at the day program on December 3, 2008 at 12:40 PM revealed Resident #3 was engaged in a table top activity (bingo) with four other peers. Resident #3 was observed to turn the bingo wheel to mix up the numbers with her left hand with physical assistance from staff. Resident #3's right hand was observed to be in a curled position. Additional observations at the group home from 4:21 PM to 8:00 PM revealed that Resident #3's right hand remained in a curled position throughout the evening.

Review of the Resident #3's Physician's Orders (POs) dated November 2008 on December 4, 2008 at 10:28 AM revealed the Resident #3 was to wear a right hand wrist splint eight (8) hours daily for right hand contractures. Interview with the Qualified Mental Retardation Professional (QMRP) on December 4, 2008 at approximately 10:30 AM revealed that she was uncertain as to what time of the day the splint should have been worn. Additional interview with the GHMRP's Registered Nurse (RN) on the same day at 11:30 AM revealed that the splint should have been worn during the evening shift from 4:00 PM to 12:00 AM.

Review of Resident #3's Medication Administration Record (MAR) on December 5, 2008 at approximately 3:00 PM revealed that the LPN signed that Resident #3 wore the adaptive support (hand splint) for the time period prescribed. According to the RN, she interviewed the LPN over the phone. The LPN stated that

1395

A. BUILDING

1395

... revealed the Resident #3 was