

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1449 ROXANNA ROAD NW WASHINGTON, DC 20012
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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) COMPLETE DATE
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I 000 INITIAL COMMENTS

A licensure survey was conducted on May 24, 2010. A random sample of two residents was selected from a resident population of four males with various degrees of disabilities. The findings of this survey were based on observations at the group home, interviews with residents and residential staff as well as the review of clinical and administrative records, including incident reports.

I 090 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 Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP were maintained in a safe, orderly, and attractive manner for four of the four residents in the facility. (Residents #1, #2, #3, and #4)

The findings include:

During the inspection of the environment on May 24, 2010, beginning at 4:06 p.m., the following concerns were identified:

Interior:

1. Resident #1's bedroom door had a hole in it and the door knob's screws were loose causing the knob not be secured.

I 000

I 090

Reviewed 6/23/10
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

I 090, 1
The hole has been sealed off and the door knob tightened. The Maintenance Division of Wholistic Services Inc., will conduct monthly audits to ensure that such issues are resolved immediately.

06/23/10

Health Regulation Administration <i>Mirilla Jones</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Vice President</i>	(X6) DATE <i>6/20/10</i>
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I 090 Continued From page 1

2. Residents #2 and #4's bedroom was observed to be cluttered and not attractive. Resident #4 had three dressers, two of which were stacked on top of each other. Resident #2 had one dresser and the top dresser drawer did not have any handles. Additionally, the rug on the bedroom floor was stained and soiled.

3. Resident #3's bed comforter was soiled. Interview with the staff on May 24, 2010 at 4:30 p.m. revealed that the stains probably was from the cream that was used on the resident's body. It should be noted that there were new comforters, still in plastic bags in the GHMRP's linen closet. The resident's wall was observed with black marks near his bed and throughout bedroom wall. According to the staff, the marks throughout the bedroom was due to staff running into the wall with Resident #3's wheelchair.

4. A recliner chair located in the GHMRP's living room was broken. Interview with the staff on May 24, 2010 at 4:38 p.m. revealed the chair belonged to one of the deceased residents. The living room wall was noted to be scratched behind the same chair.

The aforementioned observations were acknowledged by the House Manager, who accompanied the surveyor during the inspection of the environment.

I 109 3504.16 HOUSEKEEPING

Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP).

I 090

I 090, 2
Resident #2's and #4's bedroom has been reorganized. One of Resident #4's dressers has been removed from the room to provide space.

Resident #2's dresser has been replaced. The new dresser has handles on all levels.

The floor carpet has been steam-cleaned.

Once monthly, Wholistic's Maintenance Division will conduct environmental audits to ensure compliance with regulations.

06/10/10

I 109

I 090, 3
Resident #3's comforter has been replaced. The House Manager or the shift nurse will on a daily basis check resident #3's comforter to ensure that it is replaced immediately whenever it is soiled.

Resident #3's bedroom will be painted to eliminate the marks.

Staff will be trained on how to safely wheel the wheelchair so as to avoid running into walls and causing marks.

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I 109 Continued From page 2

This Statute is not met as evidenced by:
 Based on the environmental inspection, the group home for mentally retarded persons (GHMRP) failed to label inconspicuously each item of clothing as belonging to a particular resident for two of the two residents in the sample. (Resident #2 and #4)

The findings include:

During the inspection of the environment on May 24, 2010, beginning at 4:06 p.m., Resident #2 and #4's bedroom was inspected. Observation of the bedroom revealed Resident #2 and #4 shared a closet. Continued observation of the resident's closet revealed the surveyor was unable to identify Resident #2's clothing from Resident #4's clothing.

At the time of the survey, the GHMRP failed to ensure Resident #2 and #4's clothing had been labeled inconspicuously.

I 109

I 090, 4
The recliner chair has been removed. The wall behind the recliner chair will be painted.

06/23/10

I 109
Resident #2's clothes have been labeled inconspicuously.

Resident #2's clothes have been labeled inconspicuously.

The House Manager (HM) on a weekly basis will check resident #2 and #4's closet to ensure that their clothes are properly arranged.

06/10/10

I 229 3510.5(f) STAFF TRAINING

Each training program shall include, but not be limited to, the following:

(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;

This Statute is not met as evidenced by:
 Based on observation, interview and record review, the group homes for persons with mental retardation (GHMRP) failed to ensure that nutritional training had been effective for staff

I 229

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I 229	<p>Continued From page 3</p> <p>(Staff #1) who prepared a snack for one of two residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>Observation of the snack on May 24, 2010 beginning at approximately 3:05 p.m. revealed one of the direct care staff offered a choice between an apple or a banana to Resident #2. The resident was observed to choose a granny smith apple. The direct care staff was observed to serve the resident a slice of apple. Continued observation during the snack time revealed the resident sitting upright in a wheelchair with both feet elevated. At 5:15 p.m., the resident was observed to independently pick up an apple slice with his right hand while holding the bowl on his lap with his left hand. Resident #2 was observed to eat the apple slices without any difficulty.</p> <p>Review of Resident #2's medical record on May 24, 2010 beginning at approximately 8:54 a.m. revealed a physician's order dated June 19, 2009. According to the physician's order, the resident was prescribed a 1600 calorie, low cholesterol, no added salt, high fiber, non concentrated sweets, chopped, mechanically soft diet.</p> <p>The inservice records were reviewed on May 24, 2010 at approximately 3:30 p.m., revealed a nutritional inservice training dated November 3, 2009. Review of the agenda revealed that the direct care staff had been trained on "different diets -modified vs. restricted. Further review of the agenda revealed mechanical soft, chopped diets were included in the training.</p> <p>At the time of the survey, the GHMRP failed to ensure Staff #1 received training that was effective in the area of Nutrition as required by</p>	I 229	<p>I 229 All Direct Support Staff (DSS) have been re-trained on diet type and texture, and portion control.</p> <p>Once weekly during the next 90 days (July 2010 – September 2010), the House Manager will observe staff during meal preparation and service to ensure that all diets and textures are adhered to as specified.</p> <p>06/23/10</p>

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I 229	Continued From page 4 this section.	I 229		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the Group Homes for Mentally Retarded Persons (GHMRP) failed to ensure that all persons making entries into the clients' records were dated and signed, for one of the two residents (Residents #2) included in the sample. The finding includes: Review of Resident #2's medical record on May 24, 2010, beginning 11:55 a.m., revealed "Annual Nursing Assessment dated August 7, 2009 and a Quarterly Nursing Assessment dated November 6, 2009. Continued review of the assessments revealed that the GHMRP's nurse had not signed the documents. During a face to face interview with the Registered Nurse (RN) Supervisor on May 24, 2010, at approximately 6:00 p.m. it was acknowledged that the aforementioned assessments had not been signed. At the time of the survey, there was no documented evidence of the signature of the Registered Nurse (RN) that conducted the "Annual and Quarterly Nursing Assessments for Resident #2.	I 291	I 291 It was an oversight by the Registered Nurse (RN). To correct such oversight, the Qualified Mental Retardation Professional (QMRP) will, on a monthly basis review all assessments completed by the RN to ensure that they are signed and dated.	06/23/10
I 379	3519.10 EMERGENCIES	I 379		

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I 379 Continued From page 5

In addition to the reporting requirement in 3519.5, 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 interview and review of the incident reports, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH) Health Regulation Administration (HRA), for one of the two residents included in the sample. (Resident #1

The finding includes:

Review of an incident report dated on April 2, 2010, on May 24, 2010, at approximately 6:30 p.m., indicated Resident #1 vomited while on the van and was taken to the emergency department (ED) for evaluation and treatment. Resident #1 was subsequently admitted to the hospital on April 3, 2010, and had a Percutaneous Endoscopic Gastrostomy (PEG) inserted on April 9, 2010. Further review revealed the Department of Health (DOH) Health Regulation Administration (HRA), was not notified of the unusual incident that substantially interfered with Resident #1's health and safety.

Interview with the Qualified Mental Retardation

I 379

I 379
Staff will be trained on incident report writing, reporting, and other related policies.

A binder has been put in place which is geared towards capturing evidence of where and when incidents reports were faxed. A fax confirmation record will be kept on file for evidence.

The QMRP will on a monthly basis keep track of parties notified of unusual incidents.

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1379	Continued From page 6 Professional (QMRP) on May 24, 2010 at approximately 12:10 p.m., revealed this unusual incident was forwarded to the DOH in April, 2010. There was no documented evidence that the GHMRP notified the Department of Health (DOH) of all unusual incidents that substantially interfered with resident's health or safety.	1379	
1401	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 staff interview and record review, facility's nursing services failed to transcribe physician medication orders on the Medication Administration Record (MAR:) according to the Principles of Nursing Documentation for one of the two residents in the sample. (Resident #1) The findings included: Review of Resident #1's physician orders (POS) dated April 13, 2010, on May 24, 2010, at approximately 1:40 p.m., revealed the facility's nursing services failed to transcribe the physician medication orders on the Medication Administration Record (MAR:) as evidenced by: (a) Acetaminophen 325 mg. tablet/60 mg every six (6) hours whenever necessary for pain via G-tube (gastric tube).	1401	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFE 12-0072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2010
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I 401	Continued From page 7 Review of the April/May 2010 MARs on May 24, 2010, at approximately 1:50 p.m. revealed Acetaminophen 325 mg. tablet/650 mg every six (6) hours whenever necessary for pain via G-tube (gastric tube) was not transcribed on the April/May, MAR. (b) Levetracetam 500mg/5ml solution per peg tube twice a day for seizures. Review of the April 2010, MAR on May 24, 2010, at approximately 1:55 p.m. revealed Levetracetam 500mg/5ml solution by mouth twice a day for seizures. Further review revealed the word "mouth " was crossed out and replaced by the word "peg". During a face to face interview with the RN Supervisor on May 24, 2010, at approximately 2:00 p.m. it was acknowledged the nursing staff had not transcribed Levetracetam 500mg/5ml solution per peg tube twice a day for seizures on the April, 2010, MARs according to the Principles of Nursing Documentation. There was no evidence the POS were documented on the Medication MARs.	I 401	I 401 The Licensed Practical Nurses (LPNs) will be in-serviced on transcribing medications on the Medication Administration Record (MAR). The facility's Registered Nurse will, on a quarterly basis compare the MARs and Physician's Order Sheets (POSs) to ensure that all medication orders on the POSs are transcribed on the MARs as specified.	06/23/10
I 404	3520.6 PROFESSIONAL SERVICES: GENERAL PROVISIONS Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRF so that relevant professional instructions can be implemented through-out the resident's programs and daily activities. This Statute is not met as evidenced by: Based on staff interview and record review, the	I 404		

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I 404	Continued From page 8 group home for mentally retarded persons (GHMRP) failed to ensure that all staff working with residents received relevant professional instructions to ensure correct implementation for appropriate dermatology interventions for one of the two residents (Resident #?) included in the sample. The finding includes: Review of Resident #2's medical record on May 24, 2010 at approximately 12:29 p.m. revealed the resident was seen by a dermatologist on May 19, 2009. The dermatologist indicated Resident #2's Seborrhea Dermatitis had resolved and recommended Nizoral shampoo weekly to the resident's scalp for prevention. During the inspection of the environment on May 24, 2010, beginning at 4:06 p.m., interview with the House Manager (HM) was conducted to ascertain information regarding if the shampoo had been provided for Resident #2. According to the HM, the resident did not have the shampoo in his hygiene kit. At 4:45 p.m., interview with the group home's Licensed Practical Nurse (LPN) revealed the shampoo was available and proceeded to the medication cabinet to show the surveyor. Continued interview with the LPN revealed Ketoconazole 2% shampoo was available for the resident. The LPN indicated that the staff are suppose to ask for the shampoo when they run out. The surveyor informed the nurse that during the environmental inspection the shampoo was not in the resident's hygiene kit. At the time of the survey, the nursing staff failed to ensure that the direct care staff were given	I 404 I 404 Staff have been informed to immediately notify the House Manager and LPN when topical are about to run out so that they can be replaced in a timely manner. A form has been put in place which will be used to track the use of dermatological treatments/ointment. On the form, percentile ranks of 25%, 50% 75% and 100% of usage will be used to determine when a dermatological treatment is about to be used up. Thus, an order will be placed when 75% of the ointment/lotion/cream has been used.	(X5) COMPLETE DATE 06/23/10.

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I 404 Continued From page 9
instructions to request the shampoo recommended for Resident #2.

I 406 3520.8 PROFESSIONAL SERVICES: GENERAL PROVISIONS

Each professional service provided shall be documented in each resident's record.

This Statute is not met as evidenced by:
Based on interview and record review, the GHMRP failed to ensure that each professional service provided was documented in each resident's record. (Resident: 2)

The finding includes:

Review of Resident #2's medical record on May 24, 2010, beginning at 8:54 a.m. revealed a physician's order dated July 27, 2009. According to the physician's order, Resident #2 was order an EEG to the head to assess patency of VP shunt.

During a face to face interview with the GHMRP's Registered Nurse (RN) on May 24, 2010, beginning at approximately 6:05 p.m. revealed that the EEG was completed for Resident #2. However, at the time of the survey, there was no documented evidence of the results of the recommended test.

I 406
The EEG was done as requested. This was confirmed by client #2's physician who stated on a consult, "EEG seen and normal."

The LPNs and medical escort staff have been strongly advised to ensure that all consults, labs, X-rays, EEG, etc. be filed immediately in a client's record.

On a quarterly basis, the facility's RN will review all the medical records to ensure that the afore-mentioned documents are filed in the medical records in a timely manner.

06/23/10

I 470 3522.1 MEDICATIONS

Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq.

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I 470 Continued From page 10

I 470

This Statute is not met as evidenced by:
 Based on observation interview and record review, the GHMRP failed to administer medications in compliance with the physician's order for one of two residents included in the sample that received medications. (1 resident #2)

The findings include:

1. Review of Resident #2's medical record on May 24, 2010 beginning at approximately 9:00 a.m. revealed a physician's order dated October 17, 2009. Continued review of the physician's order revealed to "continue Dilantin twice a day until Monday and confirm a new order from the neurologist." Interview with the GHMRP's Registered Nurse at 1:49 p.m. and record review revealed there was no evidence that a new order had been obtained nor was there a nursing note for verification.

Record verification of the Medication Administration Record (MAR) dated October, 2009 on May 24, 2010, beginning at 1:00 a.m. revealed Resident #2's Dilantin was to be discontinued on October 17, 2009. Review of the current physician's orders dated May 2010 revealed Resident #1 was prescribed "Dilantin, 1 cap twice daily for seizures." At the time of the survey, there was no documented evidence that a new order was confirmed with the neurologist as prescribed.

2. Review of Resident #2's medical record on May 24, 2010, at approximately 12:25 p.m. revealed the resident was seen by a dermatologist on May 19, 2009. The dermatologist noted that the resident's Dermatitis was resolved and recommended Nizoral

I 470, 1
The LPNs have been in-serviced on adhering to Physician's Orders and following with medication orders to ascertain dose, route of administration, and time of administration.

The facility's RN will on a quarterly review POSs and MARs to ensure that orders are consistently transcribed as ordered.

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I 470, 2
Cross reference I 404.

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shampoo, to be used weekly to his scalp for prevention.

During the inspection of the environment on May 24, 2010, beginning at 4:30 p.m., the House Manager (HM) was asked if Resident #2 had the Nizoral shampoo in his hygiene kit. Interview the HM revealed that the resident did not have the shampoo.

A face to face interview was conducted with the GHMRP's Licensed Practical Nurse (LPN) on May 24, 2010, at 4:45 p.m. revealed the direct care staff did not ask for the shampoo after using it on May 23, 2010. The LPN proceeded to show the surveyor that the shampoo was available for Resident #2.

Review of the label on the shampoo revealed it was prescribed every other day.

At the time of the survey, the GHMRP failed to ensure the Nizoral was administered as prescribed for Resident #2.

1470

1473 3522.4 MEDICATIONS

The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician.

This Statute is not met as evidenced by: Based on observation, interview and record verification, the Group Home for the Mentally Retarded Persons (GHMRP) failed to report any irregularities to the Primary Care Physician (PCP) for one of the two residents included in the sample. (Residents #1)

The finding includes:

1473

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HI D12-0015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1449 ROXANNA ROAD NW WASHINGTON, DC 20012
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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) COMPLETE DATE
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Review of Resident #1's discharge summary dated April 13, 2010, on May 24, 2010, at approximately 2:25 p.m., revealed the patient was diagnosed with a right axilla abscess and was prescribed Batrium DS one (1) tablet twice a day until April 20, 2010.

Review of Resident #1's physician orders (POS) dated April 13, 2010, on May 24, 2010, at approximately 2:30 p.m., an order for Batrium DS one (1) tablet in the morning and one (1) tablet at night, last dose April 20, 2010.

Review of the April 2010, MAR on May 24, 2010, at approximately 1:55 p.m. revealed no documented evidence Batrium DS one tablet was administered at 7:00 a.m. on April 14, 2010.

During a face to face interview with the Registered Nurse (RN) Supervisor on May 24, 2010, at approximately 2:40 p.m. it was acknowledged the nursing staff had not documented Batrium DS one tablet was administered at 7:00 a.m. on April 14, 2010. Further interview revealed the Primary Care Physician (PCP) was not made aware of any medication irregularities.

There was no evidence the PCP was not made aware of any medication irregularities.

I 473

I 473
The Batrium was administered but staff (LPN) failed to document on the MAR.

The facility's RN will train the LPNs on documentation on the MAR when medications are administered.

A system has been put in place wherein if a medication is ordered for ten days, the MAR will be boxed out for the ten days the medication is to be administered. The RN will follow-up with a review of the MAR to ensure compliance.

06/23/10