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

PRINTED: 05/01/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 04/24/2009
NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 07		STREET ADDRESS, CITY, STATE, ZIP CODE: 78 53RD PLACE, SE 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	W 000		
	A recertification survey was conducted from April 22, 2009 through April 24, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of five men with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.		Stated that they sent POC back 5/15/09.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		
	The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.		Review 4/23/09 upon request	
	This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients included in the sample. (Client #2)			
	The finding includes:			
	During the entrance conference on April 22, 2009, at appropriately 3:46 PM, interview with the House Manager (HM) revealed that Client #2's sister was identified as designated surrogate		The sister for client #2 signed the consent form on 4/26/09. She was made aware verbally of the change in medication.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Jones — TITLE: Vice President — (X6) DATE: 5/15/09

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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WHOLISTIC 07	75 53RD PLACE, SE WASHINGTON, DC 20019

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W 124	Continued From page 1 healthcare decision-maker due to the client's lack of capacity to give informed consent for the use of his medications. Evening observation of the medication administration at 7:18 PM, revealed Client #2 received medications including Phenobarbital 45 mg, Luvox 150 mg, and Risperdal 3 mg by mouth. Interview with the Trained Medication Employee (TME) during the medication administration pass revealed that the aforementioned medication was used to address maladaptive behaviors. Review of Client #2's medical record on April 24, 2009 at approximately 1:40 PM, revealed a written physician's monthly consultation visit dated July 2008, that documented an increase in the client's Risperdal from 2 mg to 3 mg twice daily. Further medical record review revealed Luvox was increased from 100 mg to 150 mg twice daily in October 2008. At approximately 3:00 PM, Client #2's Psychological Assessment dated October 2008 was reviewed. According the the assessment, Client #2 did not evidence the capacity to make informed decisions on his own behalf regarding habilitation planning, placement, treatment, financial, or medical matters. Interview with the Qualified Mental Retardation Professional (QMRP) on April 24, 2009, at approximately 3:30 PM, revealed that Client #2's medication was increased due to an increase in the client's maladaptive behaviors. The QMRP was asked by the surveyor if Client #2's sister had been informed of the increase in medications and to determine if consent was obtained for the medication changes. The QMRP stated that he was unsure if the sister was informed and/or	W 124	QMRP and RN shall ascertain consent for prior to the administration of psychotropic medication moving forward.	5/8/09

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W 124	Continued From page 2 provided consent for the medication changes. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from Client #1's sister prior to the increase dosage of his psychotropic medication regimen. It should be noted that on April 27, 2009, a faxed consent form dated April 26, 2009 was received from the provider. The consent form indicated that Client #2's sister was made aware of the medication changes and signed the consent form.	W 124		
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 interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for five of five clients residing in the facility. (Client #1, #2, #3, #4, and #5) The findings include: 1. The QMRP failed to ensure that informed consent was obtained from Client #2's surrogate decision maker prior to the increase dosage in his medication regimen. [See W124] 2. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts. [See W440]	W 159	See W124 See W440	

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W 159	Continued From page 3 3. The QMRP failed to ensure fire drills were conducted under varied conditions.[See W441]	W 159	See W441	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for one of three clients included in the sample. (Client #2) The finding includes: [Cross Reference W124] The facility's human rights committee failed to ensure that informed consent had been obtained for the increased dosage in Client #2's medication regimen. Interview with House Manager (HM) on April 22, 2009, at approximately 3:45 PM during the entrance conference, revealed that Client #2's sister was his surrogate healthcare decision-maker. Interview with the Qualified Mental Retardation Professional (QMRP) on April 24, 2009, at approximately 3:30 PM revealed he was unsure if the sister was informed and/or provided consent for the medication changes. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from Client #1's sister prior to the increase dosage of his psychotropic medication regimen.	W 263	QMRP and RN shall obtain consent in a written manner prior to HRC approval of the use of psychotropic medications.	5/8/09
W 440	483.470(l)(1) EVACUATION DRILLS	W 440		

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	09G160		04/24/2009

NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 07

STREET ADDRESS, CITY, STATE, ZIP CODE: 76 53RD PLACE, SE, WASHINGTON, DC 20019

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W 440	Continued From page 4 The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts for five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5) The finding includes: Interview with the House Manager (HM)/Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on April 23, 2009, at 1:35 AM, revealed the scheduled shifts were as follows: Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the HM/QMRP revealed that the staffs were required to conduct a drill quarterly during each shift. Review of the fire drill log on April 23, 2009, at approximately 1:40 PM, revealed that the facility failed to hold fire evacuation drills quarterly on the following shifts: - During the second shift from May 2008 through July 2008 - During the first shift from August 2008 through October 2008 - During the second shift from November 2008 through January 2009	W 440	The provider is in disagreement regarding the analysis of this deficiency. Our contention is that the regulations merely require quarterly drills. When the quarter begins is not stated in the regulations. Our drills are conducted quarterly based on the calendar year. Thus Jan-March, April-June, July-Sept. & Oct-Dec. The assumption that the quarterly schedule begins in the certification year is not supported by the regulation. Based on the calendar year we conduct quarterly drills. If a provider is conducting the drills quarterly based	

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W 440	Continued From page 5 Continued interview with the HM acknowledged that fire drills had not been conducted during each shift. There was no evidence that fire drills were conducted quarterly on all shifts.	W 440	on a calendar year it is our belief that we meet the standards of the regulations. (Only this surveyor takes this narrow interpretation).	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions for five of five clients residing in the facility. (Clients #1, #2, #3, #4, and #5) The finding includes: Review of the facility's fire drill records on April 23, 2009, at 1:35 PM, revealed that most of the fire drills were conducted via the front, back, and side door exits. Interview with the House Manager (HM) on the same day at approximately 2:00 PM revealed that the facility had at least five methods of egress. Further review of the fire drill record revealed that the exit in the basement had not been used at least quarterly on each shift. The HM acknowledged that the basement exit had not been used during fire drills. There was no evidence that evacuation drills were held under varied conditions.	W 441	The fire drill schedule will be done to ensure that all exits are being utilized during fire drills.	5/15/09
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455		

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W 455	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure effective infection control procedures were implemented, for one of three clients residing in the facility. (Client #3) The finding includes: The facility failed to ensure that Client #3's hands remained sanitary during meal consumption on March 16, 2009, as evidenced below: On April 22, 2009, at approximately at 5:27 PM, direct care staff was observed to place bingo cards and bingo chips on the dining table for tabletop activities. At 6:25 PM, Client #3 was observed to eat sweet peas and rice off the place mat/dining table where staff had placed the bingo cards/chips earlier. The staff, who sat directly across from Client #3 at that time, did not encourage/provide him the opportunity to wash his hands. Additionally, staff was not observed to redirect him from eating off the table. Interview with the direct care on the same day at approximately at 7:00 PM revealed that he had received training on infection control. Review of the staff in service on April 24, 2009, at approximately 4:04 PM confirmed that all staff had received training in infection control. There was no evidence that the training to prevent infectious diseases was effective.	W 455	Nurse will retrain staff on infection control. The QMRP and HM shall observe mealtime to ensure that proper infection control procedures are being followed. Staff that fail to adhere to proper protocol shall be terminated.	5/8/09

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 07	STREET ADDRESS, CITY, STATE, ZIP CODE 78 53RD PLACE, SE WASHINGTON, DC 20018		

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 22, 2009 through April 24, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of five men with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	I 000		
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 GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner for five of five clients residing in the facility. (Client #1, #2, #3, #4, and #5) The finding includes: An environmental walk-thru conducted on April 24, 2009 beginning at 5:54 PM revealed several ceiling tiles located in the room near the front door entrance, with water damage. Interview with the House Manage acknowledged that the tiles needed to be replaced.	I 090	Tiles have been replaced.	5/7/09
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in	I 135		

Health Regulation Administration

Miatta Thomas

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

TITLE Vice President

(X6) DATE 5/15/09

STATE FORM

C8NJ11

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I 135	Continued From page 1 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 staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts for five of five resident residing in the GHRMP. (Clients #1, #2, #3, #4, and #5) The finding includes: Interview with the House Manager (HM)/Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on April 23, 2009, at 1:35 AM, revealed the scheduled shifts were as follows: Weekdays/Weekends 1st Shift 8 AM to 4 PM 2nd Shift 4 PM to 12 AM 3rd Shift 12 AM to 8 PM Further interview with the HM/QMRP revealed that the staffs were required to conduct a drill quarterly during each shift. Review of the fire drill log on April 23, 2009, at approximately 1:40 PM, revealed that the GHRMP failed to hold fire evacuation drills quarterly on the following shifts: - During the second shift from May 2008 through July 2008 - During the first shift from August 2008 through October 2008 - During the second shift from November 2008 through January 2009 Continued interview with the HM acknowledged that fire drills had not been conducted during	I 135	See W440	

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I 135	Continued From page 2 each shift. There was no evidence that fire drills were conducted quarterly on all shifts.	I 135		

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R 000	INITIAL COMMENTS	R 000		
	A licensure survey was conducted from April 22, 2009 through April 24, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of five men with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.			
R 125	4701.5 BACKGROUND CHECK REQUIREMENT	R 125		
	The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.			
	This Statute is not met as evidenced by: Based on the interview and review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for 10 of 12 personnel records reviewed.		The provider disagrees with this defiency. The findings fail to stipulate whether the ten staff had evidence of a criminal background check that disclosed a 7 year listing of all jurisdiction prior to employment. It's our contention that prior to employment all jurisdictions were properly researched. Once employed there is no obligation to research additional jurisdictions. Thus staff that had not lived or worked in DC prior to employment at Wholistic do not have	
	The finding includes:			
	Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel files on April 24, 2009, at 4:30 PM, revealed the GHMRP failed to provide evidence of a criminal background checks that disclosed a seven year listing of all jurisdictions where ten (10) staff persons had worked or resided at the time of the survey.			

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitta Ross

TITLE: Vice President

(X6) DATE: 5/15/09

STATE FORM

C8NJ11

If continuation sheet 1 of 2

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			background checks that research DC. We believe that this is consistent with the regulatory requirements given that they clear state prior to employment.	