

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

0002/0040
PRINTED: 06/07/2010
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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 |
|--|---------------|---|----------------------|

| | | | |
|---|---------------------|---|-----------------------|
| <p>W 000 INITIAL COMMENTS</p> <p>A recertification survey was conducted from 5/11/2010 through 5/13/2010. The survey was completed utilizing the fundamental survey process.</p> <p>A random sampling of two clients was selected from a residential population of four males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the client and administrative records, including the incident reports.</p> | <p>W 000</p> | <p><i>Received 6/21/10</i></p> <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</p> | |
| <p>W 140 483.420(b)(1)(i) CLIENT FINANCES</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a full and accurate account of all clients' funds for three of four clients residing in the facility. (Clients #2, #3 and #4)</p> <p>The findings include:</p> <p>1. Review of Client #2's financial records on 5/13/2010 at approximately 1:30 p.m. revealed \$200.00 was withdrawn from his account on 6/10/2009. There was no evidence on file at that time to substantiate what the withdrawal was for or on what it was spent.</p> <p>Interview with the QMRP on 5/13/2010, at 1:37</p> | <p>W 140</p> | <p>The surveyor was shown a faxed copy of the receipts and the QMRP gave him a copy of the receipts prior to him exiting the home. QMRP will ensure that a copy of all receipts is maintained in the facility at all times.</p> | <p>5/13/10</p> |

| | | |
|---|--------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mattie Thomas</i> | TITLE <i>Vice President</i> | (X6) DATE <i>6/17/10</i> |
|---|--------------------------------|-----------------------------|

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES0003/0040
PRINTED: 06/07/2010
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 05/13/2010 |
| 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 140 | <p>Continued From page 1</p> <p>p.m., confirmed there was no written documentation on file to explain or support the reason for the withdrawal. The QMRP further added that he would check with the management office to see if he could find out what the withdrawal was for and to find receipts for the expenditures.</p> <p>The facility failed to ensure a full and complete accounting of Client #2's funds.</p> <p>2. Review of Client #3's financial records on 5/13/2010, at approximately 1:40 p.m., revealed \$250.00 was withdrawn from his account on 6/3/2009. There was no evidence on file at the time of the survey to substantiate what the withdrawal was for, or to verify how it was spent.</p> <p>Interview with the QMRP on 5/13/2010, at 2:07 p.m. confirmed there was no written documentation on file to explain or support the reason for the withdrawal. The QMRP further added that he would check with the management office to see if he could find out what the withdrawal was for and to find receipts of what it was spent on.</p> <p>The facility failed to ensure a full and complete accounting of Client #3's funds.</p> <p>3. Review of Client #4's financial records on 5/13/2010, at approximately 1:50 p.m., revealed \$200.00 was withdrawn from his account on 6/3/2009. There was no evidence on file at the time of the survey to substantiate what the withdrawal was for or to verify how the money was spent.</p> <p>Interview with the QMRP on 5/13/2010 at 2:06</p> | W 140 | |

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

| | | | | |
|---|--|---|---|---|
| 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 05/13/2010 |
| 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 140 | Continued From page 2 p.m. confirmed there was no written documentation on file to explain or support the reason for the withdrawal. The QMRP further added that he would check with the management office to see if he could find out what the withdrawal was for, and to obtain receipts for the expenditures. | W 140 | | |
| W 159 | The facility failed to ensure a full and complete accounting of Client #4's funds. 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 observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for four of the four clients residing in the facility. (Clients #1, #2, #3, and #4) The findings include: 1. The facility's QMRP failed to ensure a full and accurate account of all clients' funds. (See W140) 2. The facility's QMRP failed to coordinate and monitor mealtime services for Clients #1, #2, #3, and #4 to ensure the accurate implementation of the planned menus. (See W192) 3. The facility's QMRP failed to coordinate services to ensure the accurate implementation of | W 159 | See W140 See W192 | |

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

| | | | |
|--|---|--|---|
| 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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 159 | Continued From page 3 Client #2's behavior support plan. (See W249) 4. The facility's QMRP failed to coordinate services to ensure medications used to control inappropriate behavior were included as an integral part of the individual program plan (behavior support plan). (See W312) 5. The facility's QMRP failed to ensure client's received their medications as ordered. (See W369) 6. The facility's QMRP failed to ensure all staff were effectively trained to employ effective infection control measures. (See W455) 7. The facility's QMRP failed to coordinate and monitor nutrition services to ensure menus were modified as necessary to implement special diets. (See W460) 8. The facility's QMRP failed to coordinate and monitor mealtime services to ensure food textures were provided as prescribed. (See W474). | W 159 | See W249 See W312 See W369 See W445 See W460 See W474 | |
| W 192 | 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each staff was effectively trained to address the health care needs of four of four clients residing in the facility. (Clients #1, #2, #3 and #4) | W 192 | This tag speaks to the skills and competencies of the training program (i.e. materials, agenda appropriateness, relevancy of topics) not staffs ability to implement. We concede that gaps in implementation exist none the less, the findings do not support a deficient practice specific to <u>this tag</u> . | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES0006/0040
PRINTED: 06/07/2010
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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 192 Continued From page 4
The finding includes:

1. The facility failed to ensure that staff training was effective for the accurate implementation of Client #3's fluid restriction as evidenced below:

a. On 5/11/2010 at 6:45 p.m., the trained medication aide was observed to administer Client #3 five pills with approximately 1/2 cup of water. Review of the physician's orders after the medication administration revealed a physician's order dated 4/1/2010 for a "Fluid restriction 1.5 liter per day", and that the client's fluids were to be measured to ensure that the total daily intake did not exceed 1.5 liter per day.

Interview with the licensed practical nurse (LPN) on 5/13/2010 at 1:37 p.m. revealed the client was on a 1.5 liter (1500 cc) fluid restriction due to his persistently low serum sodium level. The nurse further indicated direct care staff were required to document all fluids given to the client on his hydration chart.

On 5/13/2010 at 1:58 p.m., the hydration chart revealed a breakdown of the number of ccs fluids to be given for the day (3 meals and 3 snacks), to provide a total of 1500 ccs/24 hours. It should be noted that the hydration chart for the weekends of 5/2010 (5/1, 5/2, 5/8/ and 5/9), included documentation that Client #4 received 1560 ccs, 1680 ccs, 1620 ccs, 1620 ccs of fluids totals respectively from the staff, during meals and snacks. Further review of the hydration chart revealed that no fluid intake was documented on 5/12/2010 between 4:00 p.m. and 12:00 a.m. on 5/13/2010. Additionally, at the time of the survey, there was no total fluid intake documented for 5/12/2010.

W 192

Alternatively, the RN will provide training on #3's fluid restriction and documentation.

6/17/10

The nutritionist will provide training on the menu and how to shop for food items.

6/17/10

QMRP shall provide training on Client #1 and #2's BSP.

6/17/10

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

| | | | | |
|---|--|--|--|---|
| 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 05/13/2010 |
| 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 192 | <p>Continued From page 5</p> <p>Record review on 5/13/2010, at approximately 2:30 p.m. revealed staff training by the nutritionist on 3/5/2010 on portion control, fluid restriction, weighing and measuring. At the time of the survey, however, there was now evidence the the training on management of Client #3's fluid restriction was effectively implemented by each staff.</p> <p>[Note: Laboratory values after the sodium restriction was prescribed revealed Client #3's serum sodium remained below the reference range.]</p> <p>2. The facility failed to ensure training provided to staff resulted in appropriate food substitutions to facilitate the preparation of nutritionally balanced meals for Clients #1, #2, #3, and #4, as evidenced below:</p> <p>On 5/11/2010 at 5:40 p.m., a staff was observed in the kitchen preparing spaghetti. Approximately 15 minutes later, he was observed stirring the tomato basil sauce in with the spaghetti. Observation of the container from which the tomato sauce was poured revealed it was a tomato basil sauce which contained no meat. At 5:55 p.m., the staff was observed serving Clients #1, #2, #3, and #4 their dinner meal, which consisted of spaghetti in tomato basil sauce, whole brussels sprouts, buttered garlic bread, and a cranberry drink. At the end of the meal, the clients were served mixed fruit for dessert.</p> <p>At 6:02 p.m. interview with the staff that cooked the meal indicated that dinner menu consisted of spaghetti with meat sauce, garlic bread, brussels sprouts, canned tropical mixed fruit, and</p> | W 192 | | |

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

| | | | | |
|---|---|--|---|---|
| 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 05/13/2010 |
| 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 | PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| W 192 | <p>Continued From page 6</p> <p>cranberry drink were on the menu.</p> <p>The review of the dinner menu dated 5/11/2010 on the same date at 6:02 p.m. confirmed that 1 cup of spaghetti should have been served with one half cup of meat sauce to the clients for dinner. The review of training records on 5/13/2010 at approximately 2:30 p.m. revealed the nutritionist conducted a class on 3/5/2010 during which the nutrition and portion control were discussed.</p> <p>At the time of the survey, however, there was no evidence that the nutrition training for staff had been effective to ensure that menu substitution were made from the same food group food group to ensure a protein rich food source was included in the dinner meal.</p> <p>3. The facility failed to ensure all staff were trained to accurately implement mealtime feeding protocol for Client #1, as evidenced below:</p> <p>Observation on 5/11/2010, at approximately 6:12 p.m. revealed, Client #1 sitting at the dinner table eating spaghetti in tomato sauce and whole brussels sprouts. He was later observed drinking a beverage from an 8 oz cup and finished his meal with a serving of mixed fruit. His meal was served in a high sided plate and he was also observed using a tablespoon to feed himself. As the client ate his meal, a direct care staff was observed monitoring him from the opposite end of the dining table, which was approximately six feet away.</p> <p>Client #1 was observed during the meal to lean over his high sided plate and scoop up his food. He was observed putting several scoops of</p> | W 192 | | |

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

| | | | |
|--|---|--|---|
| 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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 192 Continued From page 7

spaghetti into his mouth before taking a rest to fully chew and swallow. Each spoon of spaghetti overflowed off of the spoon and some of it spilled over the edge plate and onto the table in front of him as he ate. After he finished eating all of his spaghetti, he scooped up one of the four brussels sprouts he was served and ate it whole. He continued this process until he had eaten all four of them. He completed his meal with no apparent distress.

Review of his mealtime feeding protocol on 5/12/2010, at 3:37 p.m. , revealed, "He has a tendency to take small scoops of food with a rapid rate of intake."

The following interventions and techniques for eating and drinking were recommended:

1. Allow one to two bites of food and request that utensil be placed on plate.
2. Make certain that all food in mouth is swallowed before placing more food in mouth.
3. Provide verbal prompts or light physical touch on the shoulder of the arm that utensil is held in as needed to decrease rate of intake of foods.
4. Encourage sips of beverage throughout the meal and after meal is finished.

An assessment of the mealtime feeding protocol revealed the staff failed to implement the "Techniques for Eating and Drinking " as outlined above. For example, staff was noted to only ask Client #1 to take a sip of beverage twice during the meal.

W 192

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES0010/0040
PRINTED: 06/07/2010
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 05/13/2010 |
| 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 192 | Continued From page 8 Interview with the facility's qualified mental retardation professional (QMRP) on 5/13/2010, at 1:04 P.M. revealed, he was not aware the staff did not implement the mealtime feeding protocol as written during dinner on the evening of 5/11/2010. The QMRP further indicated he would have to conduct additional training to address the problem. The facility failed to ensure all staff was effectively trained to implement Client #1's mealtime feeding protocol to ensure his health and safety during meals. 4. Cross-Refer to W474. 2 The facility failed to ensure training was effective for the accurate implementation of prescribed food textures for Client #2, as evidenced below: On 5/11/2010, at 6:08 p.m., Client #2 appeared to be edentulous as he sat at the dining table and prepared to eat his meal. At 6:10 p.m., the client began to independently eat his dinner (spaghetti in tomato sauce, whole brussels sprouts, and bite size garlic bread) from the plate. By 6:17 p.m. he had finished eating all of his food, except the brussels sprouts. Interview with the staff revealed the client's diet should be served bite size because he had no teeth. The review of Client #2's mealtime guidelines dated 04/2010 on 5/12/2010 at 10:39 a.m., confirmed that he was edentulous, which impacted his ability to properly masticate (chew) food during eating. The speech and language pathologist (SLP) further recommended the client to receive a bite size diet. On 5/13/2010 10:42 a.m., training records revealed the speech and language pathologist provided training to staff on | W 192 | | | |

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

| | | | | | |
|---|---|---|---|----------------------|---|
| 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 05/13/2010 |
| 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 192 | Continued From page 9 4/10/2010. The training agenda documented that Mealtime Guideline/Safe Eating Techniques were discussed. At the time of the survey, however, the staff failed to demonstrate competency on the implementation of the prescribed bite-size diet. | W 192 | | | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of two clients in the sample. (Client #2) The finding includes: The facility failed to ensure interventions identified in Client #2's behavior support plan were consistently implemented as evidenced below: On 5/11/2010, at 6:36 p.m., staff was observed to verbally prompt Client #1 to wipe the dining table with a wet cloth. The client wiped a small area of the table, then stopped and hollered loudly, looking up at the staff. The client continued to require several verbal prompts each time to wipe another spot on the table. Each time staff | W 249 | Staff will be retrained on Client #2's BSP. | 6/17/10 | |

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

| | | | | |
|---|--|--|---|---|
| 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 05/13/2010 |
| 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 249 | <p>Continued From page 10</p> <p>prompted him to wipe the table, the continued to look up and holler loudly at the staff. At 6:38 p.m., the client refused to go into the kitchen to wash his hands when he was verbally prompted to do so.</p> <p>Interview with staff on 5/12/2010, at 2:39 p.m., acknowledged that screaming, yelling and non-compliance were some of the client's targeted behaviors.</p> <p>On 5/12/2010, at 2:43 p.m., the review of Client #2's BSP dated 10/06/09, confirmed the staff statements identifying the targeted behaviors. It should be noted that the BSP also provided the following instructions on how to address the non-compliance (failure to follow staff directives) and screaming/yelling:</p> <p>"If he refuses to comply with staff directives, staff should not continue to repeatedly ask him to do so. Staff should walk away, then return a few minutes later and again make the same request of [client]."</p> <p>At the time of the survey, there was no evidence Client #2's BSP was implemented as written.</p> | W 249 | | |
| W 312 | <p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record</p> | W 312 | | |

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

| | | | | |
|---|--|--|---|---|
| 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 05/13/2010 |
| 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 312 | <p>Continued From page 11</p> <p>review, the facility failed to ensure a client ' s Behavior Support Plan outlined the use of a psychotropic medication for two of two sampled clients. [Clients #1 and #2]</p> <p>The findings include:</p> <p>1. Client #1's behavior support plan failed to identify the drug(s) being used to manage his behavior and it also failed to outline how the psychotropic regimen may change in relation to the client ' s progress or regression in meeting the desired objective as outlined below:</p> <p>Observation on the evening of 5/11/2010 on 7:04 p.m. revealed, Client #1 received Seroquel 200 mg as an "anti-psychotic" control. A review of Client #1's current Physician's Order Sheets (POS) on 5/12/2010, at 2:28 p.m. revealed standing order for Seroquel prescribed on 10/11/2007. In addition, the POS prescribed 4 mg of Ativan for a dental appointment on 5/3/2010.</p> <p>Additional record review on 5/13/2010 at approximately 3:00 p.m. revealed Client #1 ' s 4/2/2010 behavior support plan (BSP) failed to outline the use or the treatment plan for incorporating the use of the Ativan or the Seroquel as a means of controlling his behavior.</p> <p>Interview and further record review with the facility's licensed practical nurse (LPN) and the qualified mental retardation professional (QMRP) on 5/13/2010 at 4:39 p.m. confirmed, Client #1 usually received 4 mg of Ativan for all his dental appointments. In addition, the LPN also stated Client #1 also received 2 mg of Ativan for his vision appointments, as well.</p> | W 312 | <p>Client #1 and #2's behavior support plan will be revised to include their use of psychotropic medication as part of their treatment plan and the use of psychotropic medication for sedation during medical appointment.</p> <p>FYI:the psychiatrist annual and quarterly reviews speak directly to this concern and are part of individual's plan. Psychiatric quarterlies are signed by psychologist and psychiatrist and are in the record.</p> | 6/17/10 |

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

| | | | | | |
|---|--|---|---|----------------------|---|
| 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 05/13/2010 |
| 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 312 | Continued From page 12 The behavior support plan failed to incorporate the use of the both the Ativan and the Seroquel in addressing Client #1 's behavior. 2. Client #2's behavior support plan failed to identify the drug(s) being used to manage his behavior and failed to define how the psychotropic regimen may be modified in response to the client's progress or regression, as evidenced below: Observation on the evening of 5/11/2010, at 6:51 p.m. revealed, Client #1 received Risperidone 3 mg for behavior. A review of Client #2's current Physician's Order Sheets (POS) on 5/12/2009 at 1:25 p.m. revealed, his order for the Risperidone 3 mg twice daily and Fluvoxamine Maleate 150 mg (Luvox) twice daily. Additional record review on 5/12/2010 at approximately 4:30 p.m. revealed Client #2's 10/6/2009 behavior support plan (BSP) failed to include the use or the treatment plan for incorporating the aforementioned medications in the plan to control his behavior. Interview and further record review with the facility's licensed practical nurse (LPN) and the QMRP on 5/13/2010 at 4:39 p.m. confirmed, that the Fluvoxamine Maleate 150 mg (Luvox) and the Risperidone were used to manage the client's behaviors. The behavior support plan, however, failed to incorporate the use of the aforementioned medication to address Client #2's behavior. | W 312 | | | |
| W 331 | 483.460(c) NURSING SERVICES | W 331 | | | |

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

| | | | |
|--|---|--|---|
| 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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 331 | <p>Continued From page 13</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of four clients residing in the facility. (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. Cross refer to W192. The facility's nursing services failed to ensure close monitoring and the accurate implementation of Client #3's prescribed fluid restriction, as evidenced below:</p> <p>Interview with the licensed practical nurse (LPN) on 5/13/2010 at 1:37 p.m. revealed that due to Client #3's persistently serum sodium level, the primary care physician (PCP) had prescribed that his fluids be restricted.</p> <p>Record review on the same day and time revealed a physician's order dated 2/25/2010, "Start fluid restriction 1.5 liter per day (1500 ml per day) due to low sodium level." Continued record review revealed a nursing risk management procedure that staff document fluid intake on the hydration chart included in the client's treatment book. The 2nd Nursing quarterly dated 2/25/2010 acknowledged the order by the PCP to restrict the client's fluids to 1.5 liter /day.</p> <p>The review of Client #4's laboratory reports on 5/13/2010, at 2:48 p.m., revealed the following results:</p> <p>1/23/2010 - sodium 132 mmol/L (Reference</p> | W 331 | See W192 | |
|-------|--|-------|----------|--|

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

| | | | | |
|---|---|--|--|---|
| 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 05/13/2010 |
| 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 331 | <p>Continued From page 14 range: 137- 145) The PCP noted "Start fluid restriction."</p> <p>3/18/2010 - sodium 129 mmol/L</p> <p>4/21/2010 - sodium 127 mmol/L. The RN noted "On fluid restricted diet."</p> <p>As reflected in the physician's orders, the fluid restriction was not implemented until one month after the PCP's 1/23/2010 recommendation. It should be noted, that at the time of the survey, the Client #3's serum sodium continued to decrease.</p> <p>2. The facility's nursing services failed to ensure a record of medication administered at the day program was maintained at the group home, as evidenced below:</p> <p>On 5/12/2010 at 10:45 a.m., interview with Client #2's day program case manager (CM) revealed that he had a past health concern of a very bad rash on his lower arms. Further interview with the CM revealed the group home and the day program had collaborated on the treatment regimen and that the rash appeared to be presently in remission. The CM indicated a topical medication had been prescribed to be used and that it was to be applied at the day program if there was redness, or other indication that the rash was returning.</p> <p>Interview with the LPN on 5/13/2010, at 2:57 p.m., confirmed a prescribed treatment order (dated 9/7/2009), Aveeno Anti-Itch lotion (applied to both arms 3 times a day for contact dermatitis) prescribed for the Client #2, had been effective to resolve the bilateral rash. Further interview with</p> | W 331 | <p>The RN's will ensure that physician orders are implemented in a timely manner.</p> <p>6/10/10</p> <p>The facility will ensure that the copy of the MAR from Client #2's day program is sent monthly to the home.</p> <p>6/10/10</p> | 6/10/10 |

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

| | | | |
|--|---|--|---|
| 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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 331 | <p>Continued From page 15</p> <p>the LPN however revealed that the medication administration record (MAR) documenting the application of the lotion to the client's arms at the day program was not routinely provided to the group home.</p> <p>The review of the 5/1/2010 physician's orders revealed that Client #2 continued to have an order for Aveeno Anti-Itch lotion 3 times a day and that it was not a prn order. The review of Client #2's MARs on the same date and time, however revealed no documentation to verify that Aveeno Anti-Itch lotion had been applied to his arms as prescribed when he attended his day program.</p> <p>At the time of the survey, there was no evidence nursing services had closely monitored the use of Client #2's anti-itch lotion at his day program.</p> | W 331 | | |
| W 369 | <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client 's received their medications as ordered for one of four clients residing in the facility. [Client #4]</p> <p>The findings include:</p> <p>Observation on the evening of 5/11/2010, beginning at 7:12 p.m., revealed the following medication administration errors occurred:</p> <p>1. At approximately 7:12 p.m., the nurse administering the evening medications poured 20</p> | W 369 | <p>Correct measuring cup are available in the home currently. RN shall ensure availability at all times.</p> | 6/10/10 |

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

| | | | | |
|---|--|--|---|---|
| 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 05/13/2010 |
| 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 369 | <p>Continued From page 16</p> <p>ml of Enulose and prepared to provide it to Client #4. Upon further inspection, the dosage outlined on Client #4's bottle was listed as 15 ml. Interview with the nurse at approximately 7:14 p.m. confirmed he had poured 20 ml into the small measurement cup.</p> <p>The nurse attempted to pour the excess medication back into the medication bottle, but could not accurately measure 15 ml of the Enulose because the graduated measurements on the small medication cup started at 20 ml. Another quick interview with the nurse on the same night at approximately 7:15 p.m. confirmed, the small measurement cup did not have any graduated markers below 20 ml. The nurse also confirmed he could not accurately measure 15 ml with the measuring cup he was using.</p> <p>2. At approximately 7:28 p.m., the nurse gestured to the staff that he was done with Client #4 and asked him to bring Client #4 back upstairs and to bring the next client down to receive their medications. When the nurse instructed the staff to send Client #4 back upstairs to the living room, he forgot to give Client #4 his Enulose. As Client #4 began to leave the basement, this surveyor asked the nurse what he was going to do with the Enulose that remained on the table. The nurse immediately prompted the staff to bring Client #4 back to the nursing station and attempted to get Client #4 to drink his Enulose. As he attempted this, Client #4 grabbed the nurse's arm and cause some of the medication to fall on the floor. Client #4 appeared reluctant to take the medication. After a little coaxing, the nurse eventually got Client #4 to drink the Enulose, but there was no way to ensure Client #4 received the required 15 ml of the medication as prescribed.</p> | W 369 | <p>The RN shall re-train the TME on medication administration measurements.</p> | 6/17/10 |

| | | | |
|--|---|--|---|
| 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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 369 | Continued From page 17 | W 369 | | |
| | The facility failed to ensure Client #4 received his evening dosage of 15 ml of Enulose as prescribed. | | | |
| W 455 | 483.470(l)(1) INFECTION CONTROL | W 455 | An active program for the prevention, control and investigation of infection and communicable diseases exist. Again, the findings do not support this deficiency tag. Nonetheless, the RN will re-train staff on infection control as it pertains to medication administration. | 6/17/10 |
| | <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff were effectively trained to employ effective infection control measures for two of two sampled clients. [Clients #1 and #2]</p> <p>The finding includes:</p> <p>The facility failed to ensure its staff implemented proper infection control measures during the evening medication administration as outlined below:</p> <p>Observation on the evening of 5/11/2010, at approximately 6:50 p.m., revealed Client #2 received his evening medications. After he swallowed his medications, Client #2 was instructed by the nurse to take his cup upstairs and put it in the kitchen sink. Client #2 refused and began to vocalize loudly. Client #2 was redirected three times by the nurse to take his cup upstairs. On each of the three redirections, Client #2's vocalizations became more animated and louder. Client #2 then placed his cup on the table next to the nursing station and quickly walked back upstairs.</p> | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES0020/0040
PRINTED: 06/07/2010
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 05/13/2010 |
|--|---|--|---|

| | |
|---|--|
| 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 455 Continued From page 18

At 7:02 p.m. Client #1 was brought downstairs by staff to receive his evening medications. Client #1 was observed to receive assistance from staff to pour his water into the cup that was on the table next to the nurse's station. The nurse administered Client #1 his evening medications and prompted Client #1 to drink his water before leaving the basement to return to the living room.

Upon further inspection, the cup that was used by Client #1 was the exact same cup that Client #2 had used a few minutes earlier.

Interview with the nurse at 7:10 p.m. confirmed, the cup that Client #1 used was the same cup that Client #2 used to drink his water after swallowing his medications. The nurse indicated the changing of the cup and/or ensuring Client #1 used a clean cup for his water was an oversight.

The nurse and the staff who accompanied Client #2 down to the basement failed to effectively communicate with each other to ensure Client #1 was provided a clean cup to use.

W 455

W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES

Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure therapeutic diets met the needs of two of four clients residing in the facility. (Clients #2 and #3)

The finding includes:

W 460

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

| | | | |
|--|---|--|---|
| 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 05/13/2010 |
|--|---|--|---|

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 460 Continued From page 19

W 460

The facility failed to ensure Clients #2 and #3 received a high fiber diet as prescribed as evidenced below:

1. On 5/12/2010 at 6:10 p.m., Client #3 was observed to receive spaghetti in tomato sauce, whole brussels sprouts, and bite-size garlic bread. He was later observed to receive canned tropical fruit for dessert.

The review of Client #3's annual nutritional assessment dated 8/25/2009, on 5/13/2010 at 2:17 p.m., revealed a high fiber diet should help manage his diverticulosis. The review of current diet order dated 5/1/2010 revealed the client was prescribed a low fat, low cholesterol, high fiber, 1500 cc fluid restricted diet. A note on the menu documented the client should receive a Low Fat, Low Cholesterol, High Fiber diet, 1500 ml (cc) Fluid Restriction diet. The menu further noted that the client should be limited to single portions of all foods except vegetables and that turkey breast should be substituted for fish.

At the time of the survey, there was no evidence the menu provided additional and specific instructions on how to modify the menu to further provide Client #3 with a high fiber diet.

2. On 5/11/2010, at 6:08 p.m., Client #2 appeared to be edentulous as he sat at the dining table and prepared to eat his meal.

At 6:10 p.m., Client #2 began to independently eat his dinner (spaghetti in tomato sauce, whole brussels sprouts, and bite size garlic bread) from the plate. By 6:17 p.m. he had finished eating all of the food on the plate except the brussels

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES0023/0040
PRINTED: 06/07/2010
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 05/13/2010 |
| 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 460 | Continued From page 20 sprouts. Interview with the staff at the home on 5/11/2010, at 5:55 p.m., revealed Client #2 revealed that because the resident had no teeth, he received a bite-size diet. Additionally, staff indicated that the client should receive a high fiber diet. Record review on 5/12/2010 at 2:39 p.m. revealed Client #2 was prescribed a low fat, no added salt, high fiber, bite-sized diet. Further record review revealed the client was prescribed medication for gastroesophageal reflux disease and gastritis (GERD). At the time of the survey, however, there was no evidence the dinner meal was in compliance with a high fiber diet or that the written menus provided specific instructions on how to provide Client #2 with a high fiber diet and minimize his risks of GERD and GI symptoms. | W 460 | | | |
| W 474 | 483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the texture of foods was provided as provided as prescribed for two of two clients in the sample. (Clients #1 and #2) The finding includes: 1. The facility failed to ensure Client #1's chopped diet was provided as prescribed as evidenced below. Observation on 5/11/2010 at approximately 6:12 | W 474 | | | |

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

| | | | | |
|---|--|--|---|---|
| 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 05/13/2010 |
| 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 474 | <p>Continued From page 21</p> <p>p.m. revealed, Client #1 sitting at the dinner table eating spaghetti in a tomato based sauce and whole Brussels sprouts. He was later observed drinking a beverage from an 8 oz cup and finishing his meal with a serving of canned tropical mixed fruit.</p> <p>During his meal, he was observed to lean over his high sided plate and scoop up his food. He was observed putting several scoops of spaghetti into his mouth before taking a rest to fully chew and swallow. Each spoon of spaghetti overflowed off of the spoon and some of it spilled over the plate and onto the table in front of him as he ate. After he finished eating all of his spaghetti, he scooped up one of the four Brussels sprouts he was served and ate it whole. He continued this process until he had eaten all four of them. He completed his meal with no apparent distress.</p> <p>Review of his nutritional assessment and physician's order sheets (POS) on 5/12/2010 at 4:27 p.m. revealed Client #4 was prescribed a "chopped" texture diet.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on 5/13/2010, at 1:05 p.m. revealed, he was not aware the staff did not implement the Client #1's food texture requirements as written during dinner on the evening of 5/11/2010. The QMRP further indicated he would have to conduct additional training to address the problem.</p> <p>2. On 5/11/2010, at 6:08 p.m., Client #2 appeared to be edentulous as he sat at the dining table and prepared to eat his meal.</p> <p>At 6:10 p.m., Client #2 began to independently</p> | W 474 | <p>Nutritionist shall provide an in-service training on food texture.</p> | 6/17/10 |

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

| | | | | |
|---|---|--|--|---|
| 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 05/13/2010 |
| 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 474 | Continued From page 22 eat his dinner (spaghetti in tomato sauce, whole brussels sprouts, and bite-size garlic bread) from the plate. By 6:17 p.m. he had finished eating all of the food on the plate except the brussels sprouts. Interview with the staff at the home on 5/11/2010, at 5:55 p.m., revealed Client #2 should have his food cut to bite size. The review of Client #2's mealtime guidelines dated 04/2010 on 5/12/2010, at 10:39 a.m., revealed that he was edentulous, which impacted his ability to properly masticate (chew) food during eating. The speech and language pathologist (SLP) further recommended the client to receive a bite size diet. At the time of the dinner meal, there was no evidence the facility ensure that Client #2 received all food in a bite size as prescribed. | W 474 | Nutritionist shall provide in-service training on food texture. | 6/17/10 |
| W 478 | 483.480(c)(1)(ii) MENUS Menus must provide a variety of foods at each meal. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the menu served for dinner provided the recommended variety of foods for four of four clients residing in the facility. (Clients #1, #2, #3, and #4). The finding include: Cross refer to W192.2. The facility failed to ensure food substitutions were made within the same food group to provide a nutritionally | W 478 | Menus at this facility provide a variety of food at each meal. This tag speaks to the menus and not the staffs implementation there of. Staff shall be trained on how to substitute within the same food group. | 6/17/10 |

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

| | | | | |
|---|---|--|---|---|
| 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 05/13/2010 |
| 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 478 | <p>Continued From page 23</p> <p>balanced meal, as evidenced below:</p> <p>On 5/11/2010 at 5:40 p.m., a staff was observed in the kitchen preparing spaghetti. Approximately 15 minutes later, he was observed stirring the tomato basil sauce in with the spaghetti. Observation of the container from which the tomato sauce was poured revealed it was a tomato basil sauce which contained no meat. At 5:55 p.m., the staff was observed serving Clients #1, #2, #3, and #4 their dinner meal, which consisted of spaghetti in tomato basil sauce, whole brussels sprouts, buttered garlic bread, and a cranberry drink. At the end of the meal, the clients were served mixed fruit for dessert.</p> <p>On 5/11/2010 at 6:02 p.m., interview with the staff that cooked the meal indicated that the clients should have received spaghetti with meat sauce.</p> <p>The review of the dinner menu dated 5/11/2010 on the same date at 6:02 p.m. confirmed that the clients should have received 1 cup of spaghetti and one half cup of meat sauce. At the time of the survey, however, there was no evidence that staff had substituted a food from the same group as the meat sauce for the dinner meal to ensure that the clients received the amount of protein recommended by the nutritionist.</p> | W 478 | | |

Health Regulation Administration

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) |
| I 000 | INITIAL COMMENTS A re-licensure survey was conducted from 5/11/2010 through 5/13/2010. A random sampling of two residents was selected from a residential population of four males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the client and administrative records, including the incident 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 staff interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the proper maintenance of the facility's environment for four of four residents [Residents #1, #2, #3, and #4] residing in the facility as identified below: The findings include: During the environmental inspection on 5/13/2010 at approximately 4:30 p.m., the following deficient practices were identified: 1. Two of the three windows in the dining room were observed to slide downward when opened, unless they were manually supported, or a prop was used. | I 090 | The facility will ensure that the windows, window screen and gutters are fixed. 6/25/10 |

Health Regulation Administration

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

M. J. Jones

TITLE

Vice President

(X6) DATE

6/17/10

STATE FORM

6899

Q1PF11

If continuation sheet 1 of 12

Health Regulation Administration

| | | | | | |
|---|---|---|---|--------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE | |
| I 090 | Continued From page 1 2. The window on the east side of the dining room was without a window screen. When opened to allow fresh ventilation on the evening of 5/13/2010 at approximately 1:00 p.m., a large wasp entered the dining area and was not able to find its way back out the window. 3. The gutter along the front of the home (second level) was bent downward. | I 090 | | | |
| I 180 | 3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the GHMRP failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for four of the four residents residing in the GHMRP. (Residents #1, #2, #3, and #4) The findings include: 1. The GHMRP's QMRP failed to ensure a full and accurate account of all residents' funds. (See W140) 2. The GHMRP's QMRP failed to coordinate and monitor mealtime services for Residents #1, #2, #3, and #4 to ensure the accurate implementation of the planned menus. (See W192) 3. The GHMRP's QMRP failed to coordinate services to ensure the accurate implementation of Resident #2's behavior support plan. (See | I 180 | See W140 See W192 See W249 | | |

Health Regulation Administration

| | | | | | |
|---|---|---|---|--------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE | |
| I 180 | Continued From page 2 W249) 4. The GHMRP's QMRP failed to coordinate services to ensure medications used to control inappropriate behavior were included as an integral part of the individual program plan (behavior support plan). (See W312)TAG LOCKED ; UNABLE TO EDIT 5. The GHMRP's QMRP failed to ensure resident's received their medications as ordered. (See W369) 6. The GHMRP's QMRP failed to ensure all staff were effectively trained to employ effective infection control measures. (See W455) 7. The GHMRP's QMRP failed to coordinate and monitor nutrition services to ensure menus were modified as necessary to implement special diets. (See W460) 8. The GHMRP's QMRP failed to coordinate and monitor mealtime services to ensure food textures were provided as prescribed. (See W474). | I 180 | See W312 See W369 See W455 See W460 See W474 | | |
| 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, staff interview and record | I 229 | | | |

Health Regulation Administration

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| I 229 | <p>Continued From page 3</p> <p>review, the GHMRP failed to ensure all staff were effectively trained to implement a resident's mealtime feeding protocol for one of two sampled residents. [Resident #1]</p> <p>The finding includes:</p> <p>The GHMRP failed to ensure all staff were trained to accurately implement the mealtime feeding protocol for Resident #1, as evidenced below:</p> <p>Observation on 5/11/2010, at approximately 6:12 p.m. revealed, Resident #1 sitting at the dinner table eating spaghetti in tomato sauce and whole brussels sprouts. He was later observed drinking a beverage from an 8 oz cup and finished his meal with a serving of mixed fruit. His meal was served in a high sided plate and he was also observed using a tablespoon to feed himself. As the resident ate his meal, a direct care staff was observed monitoring him from the opposite end of the dining table, which was approximately six feet away.</p> <p>Resident #1 was observed during the meal to lean over his high sided plate and scoop up his food. He was observed putting several scoops of spaghetti into his mouth before taking a rest to fully chew and swallow. Each spoon of spaghetti overflowed off of the spoon and some of it spilled over the edge plate and onto the table in front of him as he ate. After he finished eating all of his spaghetti, he scooped up one of the four brussels sprouts he was served and ate it whole. He continued this process until he had eaten all four of them. He completed his meal with no apparent distress.</p> <p>Review of his mealtime feeding protocol on</p> | I 229 | See W192 |

Health Regulation Administration

| | | | | |
|---|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| I 229 | <p>Continued From page 4</p> <p>5/12/2010, at 3:37 p.m. , revealed, "He has a tendency to take small scoops of food with a rapid rate of intake."</p> <p>The following interventions and techniques for eating and drinking were recommended:</p> <ol style="list-style-type: none"> 1. Allow one to two bites of food and request that utensil be placed on plate. 2. Make certain that all food in mouth is swallowed before placing more food in mouth. 3. Provide verbal prompts or light physical touch on the shoulder of the arm that utensil is held in as needed to decrease rate of intake of foods. 4. Encourage sips of beverage throughout the meal and after meal is finished. <p>An assessment of the mealtime feeding protocol revealed the staff failed to implement the "Techniques for Eating and Drinking " as outlined above. For example, staff was noted to only ask Resident #1 to take a sip of beverage twice during the meal.</p> <p>Interview with the GHMRP's qualified mental retardation professional (QMRP) on 5/13/2010, at 1:04 P.M. revealed, he was not aware the staff did not implement the mealtime feeding protocol as written during dinner on the evening of 5/11/2010. The QMRP further indicated he would have to conduct additional training to address the problem.</p> <p>The GHMRP failed to ensure all staff was effectively trained to implement Resident #1's mealtime feeding protocol to ensure his health and safety during meals.</p> | I 229 | | |

Health Regulation Administration

| | | | | |
|---|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| I 401 | <p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services were provided in accordance with the needs of four of four resident in the GHMRP. (Residents #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>I. The GHMRP failed to ensure nursing services were provided in accordance with the needs of Residents #2 and #3, as evidenced below:</p> <p>A. Cross refer to W192. The GHMRP's nursing services failed to ensure close monitoring and the accurate implementation of Resident #3's prescribed fluid restriction, as evidenced below:</p> <p>Interview with the licensed practical nurse (LPN) on 5/13/2010 at 1:37 p.m. revealed that due to Resident #3's persistently serum sodium level, the primary care physician (PCP) had prescribed that his fluids be restricted.</p> <p>Record review on the same day and time revealed a physician's order dated 2/25/2010, "Start fluid restriction 1.5 liter per day (1500 ml per day) due to low sodium level." Continued record review revealed a nursing risk management procedure that staff document fluid intake on the hydration chart included in the</p> | I 401 | See W192 | |

Health Regulation Administration

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| I 401 | <p>Continued From page 6</p> <p>resident's treatment book. The 2nd Nursing quarterly dated 2/25/2010 acknowledged the order by the PCP to restrict the resident's fluids to 1.5 liter /day.</p> <p>The review of Resident #4's laboratory reports on 5/13/2010, at 2:48 p.m., revealed the following results:</p> <p>1/23/2010 - sodium 132 mmol/L (Reference range: 137- 145) The PCP noted "Start fluid restriction."</p> <p>3/18/2010 - sodium 129 mmol/L</p> <p>4/21/2010 - sodium 127 mmol/L. The RN noted "On fluid restricted diet."</p> <p>As reflected in the physician's orders, the fluid restriction was not implemented until one month after the PCP's 1/23/2010 recommendation. It should be noted, that at the time of the survey, the Resident #3's serum sodium continued to decrease.</p> <p>B. The GHMRP's nursing services failed to ensure a record of medication administered at the day program was maintained at the group home, as evidenced below:</p> <p>On 5/12/2010 at 10:45 a.m., interview with Resident #2's day program case manager (CM) revealed that he had a past health concern of a very bad rash on his lower arms. Further interview with the CM revealed the group home and the day program had collaborated on the treatment regimen and that the rash appeared to be presently in remission. The CM indicated a topical medication had been prescribed to be used and that it was applied at the day program</p> | I 401 | |

Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
|---|--|--|---|
| 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) COMPLETE DATE |
| I 401 | <p>Continued From page 7</p> <p>if there was redness, or other indication that the rash was returning and had been effective.</p> <p>Interview with the LPN on 5/13/2010, at 2:57 p.m., confirmed a prescribed treatment order (dated 9/7/2009), Aveeno Anti-Itch lotion (applied to both arms 3 times a day for contact dermatitis) prescribed for the Resident #2, had been effective to resolve the bilateral rash. Further interview with the LPN however revealed that the medication administration record (MAR) documenting the application of the lotion to the resident's arms at the day program was not routinely provided to the group home.</p> <p>The review of the 5/1/2010 physician's orders revealed that Resident #2 continued to have an order for Aveeno Anti-Itch lotion 3 times a day and that it was not a prn order. The review of Resident #2's MARs on the same date and time, however revealed no documentation to verify that Aveeno Anti-Itch lotion had been applied to his arms as prescribed when he attended his day program.</p> <p>At the time of the survey, there was no evidence nursing services had closely monitored the use of Resident #2's anti-itch lotion at his day program.</p> <p>II. The GHMRP failed to ensure resident's received their medications as ordered for Residents #4, as evidenced below:</p> <p>On 5/11/2010, at approximately 7:12 p.m., the nurse administering the evening medications poured 20 ml of Enulose and prepared to provide it to Resident #4. Upon further inspection, the dosage outlined on Resident #4's bottle was listed as 15 ml. Interview with the nurse at approximately 7:14 p.m. confirmed he had</p> | I 401 | |

Health Regulation Administration

| | | | | |
|---|---|--|---|--------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 | |
| 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) COMPLETE DATE |
| I 401 | <p>Continued From page 8</p> <p>poured 20 ml into the small measurement cup.</p> <p>The nurse attempted to pour the excess medication back into the medication bottle, but could not accurately measure 15 ml of the Enulose because the graduated measurements on the small medication cup started at 20 ml. Another quick interview with the nurse on the same night at approximately 7:15 p.m. confirmed, the small measurement cup did not have any graduated markers below 20 ml. The nurse also confirmed he could not accurately measure 15 ml with the measuring cup he was using.</p> <p>On 5/11/2010, at approximately 7:28 p.m., the nurse gestured to the staff that he was done with Resident #4 and asked him to bring Resident #4 back upstairs and to bring the next resident down to receive their medications. When the nurse instructed the staff to send Resident #4 back upstairs to the living room, he forgot to give Resident #4 his Enulose. As Resident #4 began to leave the basement, this surveyor asked the nurse what he was going to do with the Enulose that remained on the table. The nurse immediately prompted the staff to bring Resident #4 back to the nursing station and attempted to get Resident #4 to drink his Enulose. As he attempted this, Resident #4 grabbed the nurse's arm and cause some of the medication to fall on the floor. Resident #4 appeared reluctant to take the medication. After a little coaxing, the nurse eventually got Resident #4 to drink the Enulose, but there was no way to ensure Resident #4 received the required 15 ml of the medication as prescribed.</p> <p>The GHMRP failed to ensure Resident #4 received his evening dosage of 15 ml of Enulose as prescribed.</p> | I 401 | | |

Health Regulation Administration

| | | | | | |
|---|--|---|---|--------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE | |
| I 401 | Continued From page 9 III. The GHMRP failed to ensure all staff were effectively trained to employ effective infection control measures for Residents #1 and #2, as evidenced below: Observation on the evening of 5/11/2010 at approximately 6:50 p.m. revealed Resident #2 received his evening medications. After he swallowed his medications, Resident #2 was instructed by the nurse to take his cup upstairs and put it in the kitchen sink. Resident #2 refused and began to vocalize loudly. Resident #2 was redirected three times by the nurse to take his cup upstairs. On each of the three redirections, Resident #2's vocalizations became more animated and louder. Resident #2 then placed his cup on the table next to the nursing station and quickly walked back upstairs. At 7:02 p.m. Resident #1 was brought downstairs by staff to receive his evening medications. Resident #1 was observed to receive assistance from staff to pour his water into the cup that was on the table next to the nurse's station. The nurse administered Resident #1 his evening medications and prompted Resident #1 to drink his water before leaving the basement to return to the living room. Upon further inspection, the cup that was used by Resident #1 was the same cup that Resident #2 had used a few minutes earlier. Interview with the nurse at 7:10 p.m., confirmed the cup that Resident #1 used was the same cup that Resident #2 used to drink his water after swallowing his medications. The nurse indicated the changing of the cup and/or ensuring Resident #1 used a clean cup for his water was an | I 401 | | | |

Health Regulation Administration

| | | | |
|---|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| I 401 | <p>Continued From page 10 oversight.</p> <p>The nurse and the staff who accompanied Resident #2 down to the basement failed to effectively communicate with each other to ensure Resident #1 was provided a clean cup to use.</p> <p>IV. The GHMRP failed to ensure therapeutic diets met the needs of Residents 2 and #3, as evidenced below:</p> <p>A. On 5/12/2010 at 6:10 p.m., Resident #3 was observed to receive spaghetti in tomato sauce, whole brussels sprouts, and bite-size garlic bread. He was later observed to receive canned tropical fruit for dessert.</p> <p>The review of Resident #3's annual nutritional assessment dated 8/25/2009, on 5/13/2010, at 2:17 p.m., revealed a high fiber diet should help manage his diverticulosis. The review of current diet order dated 5/1/2010 revealed the resident was prescribed a low fat, low cholesterol, high fiber, 1500 cc fluid restricted diet. A note on the menu documented the resident should receive a Low Fat, Low Cholesterol, High Fiber diet, 1500 ml (cc) Fluid Restriction diet. The menu further noted that the resident should be limited to single portions of all foods except vegetables and that turkey breast should be substituted for fish.</p> <p>At the time of the survey, however, there was no evidence the menu provided additional and specific instructions on how to modify the menu to further provide Resident #3 with a high fiber diet.</p> <p>B. On 5/11/2010, at 6:08 p.m., Resident #2 appeared to be edentulous as he sat at the dining</p> | I 401 | |

Health Regulation Administration

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| I 401 | Continued From page 11 table and prepared to eat his meal. At 6:10 p.m., Resident #2 began to independently eat his dinner (spaghetti in tomato sauce, whole brussels sprouts, and bite size garlic bread) from the plate. By 6:17 p.m. he had finished eating all of the food on the plate except the brussels sprouts. Interview with the staff at the home on 5/11/2010, at 5:55 p.m., revealed Resident #2 revealed that because the resident had no teeth, he received a bite-size diet. Additionally, staff indicated that the resident should receive a high fiber diet. Record review on 5/12/2010 at 2:39 p.m. revealed Resident #2 was prescribed a low fat, no added salt, high fiber, bite-sized diet. Further record review revealed the resident was prescribed medication for gastroesophageal reflux disease and gastritis (GERD). At the time of the survey, however, there was no evidence the dinner meal was high in fiber, or that the written menus provided specific instructions on how to provide Resident #2 with a high fiber diet and minimize his risks of GERD and GI symptoms. | I 401 | |

Health Regulation Administration

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| R 000 | INITIAL COMMENTS A re-licensure survey was conducted from 5/11/2010 through 5/13/2010. A random sampling of two clients was selected from a residential population of four males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the resident and administrative records, including the incident reports. | R 000 | |
| R 125 | 4701.5 BACKGROUND CHECK REQUIREMENT 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 record review and staff interview, the group home for the mentally retarded person(s) (GHMRP) failed to ensure all criminal background checks covered where the employee worked or lived over the past seven (7) years as required by this section. [Staff #1 and #8] The finding includes: Interview with the facility's qualified mental retardation professional (QMRP) on 5/13/2010 at approximately 4:55 p.m. revealed the GHMR's governing body failed to ensure all staff received a complete criminal background check prior to employment as evidence below: | R 125 | Facility will ensure that a comprehensive background check is done for all employees. 6/10/10 Please be advised that regulations state lived or worked within seven years and two employees at issue are in compliance with the regulations as written. |

Health Regulation Administration

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

*Matto Shaves*TITLE
Vice President(X6) DATE
6/17/2010

STATE FORM

8899

Q1PF11

If continuation sheet 1 of 2

Health Regulation Administration

| | | | | |
|---|---|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0147 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/13/2010 |
| 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) COMPLETE DATE |
| R 125 | <p>Continued From page 1</p> <p>1. Record review on 5/13/2010 at approximately 4:35 p.m. revealed, Staff #1's job application listed him as either having worked or lived in the states of North Carolina at the time of the background screening within the past seven years. The criminal background check on record at the time of survey only covered the surrounding states of Maryland, Virginia and the District of Columbia.</p> <p>2. Record review on 5/13/2010 at approximately 4:25 p.m. revealed, Staff #8's job application listed him as either having worked or lived in the District of Columbia at the time of the background screening within the past seven years. The criminal background check on record at the time of survey only covered the State of Maryland.</p> <p>There was no evidence on file at the time of survey to substantiate that the GHMRP's governing body ensured all criminal background checks were conducted to cover the seven year requirement as cited above.</p> | R 125 | | |