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

PRINTED: 07/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
09G112			B. WING	9	0.7	7/47/2042
WHOLIS				STREET ADDRESS, CITY, STATE, ZIP COE 1226 LAWRENCE STREET, NE WASHINGTON, DC 20017		7/17/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(- i-iii - o iiii Lo iii L Ao ii Oii	SHOULDBE	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	rs .	w o	000		
W 322	15, 2013 through Ju three clients was se six males with vario This survey was init survey process. The findings of the s observations in the I programs, interviews support staff, nursin well as a review of o records, including in [Qualified mental ret (QMRP) will be refer disabilities professio 483.460(a)(3) PHYS The facility must profeseral medical care	ardation professional red to as qualified intellectual nal (QIDP) within this report.] ICIAN SERVICES vide or obtain preventive and	W 32	Color to the the training to the state of th		
	failed to ensure the ti medication prescribe	and record review, the facility				9
	administration on Juli review of the medical (MAR) revealed Clier 500 mg via G-tube tw ended on July 10, 20	ation of the medication y 15, 2013, at 6:53 p.m., tion administration record at #1 had also received Cipro vice a day for ten days, which 13. The concurrent review of	-3	See I 401		417/13
DUKATURY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		X6) DATE

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 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		09G112	B. WING	s		0	07/17/2013	
WHOLIS	PROVIDER OR SUPPLIER			122	EET ADDRESS, CITY, STATE, ZIP CODE 26 LAWRENCE STREET, NE ASHINGTON, DC 20017		771712013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D BF	(X5) COMPLETION DATE	
	a physician's order of the client was presoned infection. The supervisory reginterviewed on July ascertain why Client mg. According to supractical nurse reposite had a small amount 2013. On July 16, 2013 at laboratory report corobtained on June 18 culture were reportervealed a bacterial aeruginosa. It should 2013 (nine days later prescribed. Further interview with 16, 2013, at 2:09 p.r. not receive medicati aeruginosa until nine test were obtained by to supervisory RN # laboratory reports the primary care phy with supervisory RN was not informed of results were received At the time of the sur provide evidence that implemented to addrinfection. 2. On July 17, 2013, nursing progress not (4:00 p.m.), revealed	dated July 1, 2013, revealed bribed the Cipro for a G-tube distered nurse (RN) #1 was 16, 2013, at 2:05 p.m., to the first was prescribed Cipro 500 upervisory RN #1, a licensed red that Client #1's G-tube bount of drainage on June 18, 2:08 p.m., review of a primed that a culture was 13, 2013. The results of the don June 21, 2013 and growth of pseudomonas and be noted that on July 1, r), Cipro 500 mg was 1, confirmed Client #1 did on to treat the pseudomonas of days after the results of the sy the laboratory. According 1, the protocol was that the protocol was that the protocol was that the energy indicated she the actual date the laboratory.	W		ee F 401		8/17/13	

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				WB NO. 0938-0391		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				3		(X3) DATE SURVEY COMPLETED			
09G112		B. WING	2						
NAME OF F	PROVIDER OR SUPPLIER		J. Wille	1		0.	7/17/2013		
WHOLIS	TIC 02			91	REET ADDRESS, CITY, STATE, ZIP CODE 1226 LAWRENCE STREET, NE				
					WASHINGTON, DC 20017				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	DRE	(X5) COMPLETION		
	I TOOL TONE ON EX	SO IDENTIF TING INFORMATION)	TAG	ì	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE		
W 322	Continued From pag	ge 2	w a	222					
	eyes. The primary c	are physician (PCP) was		022					
	informed and gave a	a telephone order for							
	order was faxed to t	n both eyes for 7 days; the he pharmacy.							
	On July 17, 2013, at	: 1:28 p.m., review of a							
	physician's order da confirmed that Clien	ted January 14, 2013							
	Tobradex Ophthalm	ic solution, one drop to each							
	eye twice daily for se	even days for an eve							
	infection. The corres administration record	d, however revealed that the							
	client was not admin	istered the first dosage of							
	18, 2013 (4 days late	ic solution drops until January		78					
	Interview with superv	visory RN #1 on July 17,							
1	2013, at 2:35 p.m., re	evealed Client #2 was having ledical insurance when the							
1	medication was pres	cribed, therefore the contract							
1	pharmacy did not pro	ovide the medication cussion with supervisory RN							
10	#1 confirmed that Cli	ent #2 did not receive the							
1.1	initial dose of the pre	scribed eve drops to treat							
	it was prescribed.	uary 18, 2013, four day after			*				
1.	At the time of the survey, the facility failed to						2		
	provide evidence that	timely measures were							
	implemented to addre	ess Client #2's eye infection.							
						③			
							1		

_	Health I	Regulation & Licensir	g Administration				FORM	M APPROVED
		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
			HFD03-0009		B. WING _			*******
	NAME OF I	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY	Y, STATE, ZIP CODE	07	/17/2013
	WHOLIS			WASHIN	WRENCE S GTON, DC	TREET, NE 20017		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FILL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JIDBE	(X5) COMPLETE DATE
	1 060	2013 through July 1 residents was select males with various in the findings of the subservations in the programs, interview support staff, nursin well as a review of records, including in [Qualified mental ref (QMRP) will be refer disabilities profession 3502.18 MEAL SER Perishable foods shatemperatures in order the group how intellectual disabilities perishable foods were temperature, for six of in the facility. (Residual) The finding includes: On July 17, 2013, at the thermometer in the revealed the temperature and the temperature in the revealed the temperature.	was conducted from 7, 2013. A sample of the from a population intellectual disabilities are survey were based on the and at two days with one guardian, go and administrative esident reports. Itardation professional tred to as qualified in the anal (QIDP) within this vice. It property to conserve nutrition the stored at property and recome for persons with some for persons	of three on of six s. of direct staff, as trative al otellectual s report.] EAS er ve value. ord nsure er esiding #5, and	1000	Temperature control Sections adjusted and readings on 7 and 7/30/13 were degrees and 38 de respectively. It and will continue to m welly to ensue appropriate temper is maintained the refrigerator	Green GIDP wonther that that	
Heal		Fahrenheit (F.). Furt		е				
	(1)	/				TITLE		(VE) DATE
LABO	DRATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTA	ATIVE'S SIGN	ATURE (OH-	PLIANCE SUPERVISOR	8/	(X6) DATE
STA	TE FORM			68	99 71	DVD14	3/0	2/10

ZRYP11

Health Regulation & Licensing Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HFD03-0009 07/17/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1226 LAWRENCE STREET, NE WHOLISTIC 02 WASHINGTON, DC 20017 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1060 Continued From page 1 1060 refrigerator revealed it contained perishable foods, including, milk, eggs, fresh fruits, and vegetables. On July 17, 2013, at 10:09 a.m., the operations manager (OM) #1, instructed HM #1 to purchase a new thermometer for the refrigerator to verify that the refrigerator was maintaining the proper temperature. On July 17, 2013, at approximately 1:30 p.m., HM #1 was observed with a new thermometer which he stated would be immediately placed in the kitchen refrigerator. When checked at 5:20 p.m., the new thermometer measured 48 degrees F. According to HM #1, the refrigerator was new, and the control on the refrigerator was set at the level recommended by the manufacturer. Review of the facility's policy on Infection Control, on the same day at 5:35 p.m., revealed "Refrigeration equipment shall maintain a temperature of 40 degrees [Fahrenheit] or below." Concurrent review of the District of Columbia standard for refrigeration temperatures (25 DCMR, Food and Food Service Regulations) revealed refrigerators should be maintained between 36 degrees and 41 degrees Fahrenheit. At the time of the survey, the facility failed to ensure the refrigerator temperature was maintained within the required range. 1 090 3504.1 HOUSEKEEPING 1090 The interior and exterior of each GHMRP shall be

Health Regulation & Licensing Administration						FORM	APPROVED
STATEME	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG:		E SURVEY	
		HFD03-0009		B. WING_			·
NAME OF	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY	/, STATE, ZIP CODE	1 071	17/2013
WHOLIS	STIC 02		1226 LA		TREET. NE		
(X4) ID PREFIX TAG				ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		
1 090	Continued From page	ge 2		1 090			
	maintained in a safe	e, clean, orderly, attra		1000	Replacement trash ordered and rain	1 Cars	8/1/12
	home for individuals (GHIID) failed to ma	eginning at 9:16 a.m. manager (OM) #1 a	group abilities nt in esidents 5 and #6) , the nd home		Environmental and will endue that a trusheans are us good wonder on a regular baser Please see attach receipts.	lit all	.,,
	Observation of the b 9:19 a.m., revealed of the backyard had a f which was approximal Another of the trash long horizontal crack damaged areas on the potential entrances for	ackyard on July 17, 2 one of the large trash ound hole in it near t ately two inches in di cans was noted to ha across the front of it ne trash cans created or rodents and pests	2013, at cans in he top, ameter. ave a	e.		×	
	Interview with OM #1 2013, at 9:21 a.m., re twice a week (Wedne #1 acknowledged, he aforementioned trash condition to prevent pand pests.	evealed trash is colle esdays and Thursday owever, that the ocans were not in ad	cted /s). OM	×	5		
I 401	3520.3 PROFESSION PROVISIONS	N SERVICES: GENE	RAL	I 401			380

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PRINTED: 07/24/2013 FORM APPROVED

Health Regulation & Licensing Administration						FORM	APPROVED
STATEME	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	IPLE CONSTRUCTION	(Y3) DATI	E SURVEY
ANDFLAN	IDENTIFICATION NUMBER			Mark Stranger Land	IG:		PLETED
		*			-	**	
		HFD03-0009		B. WING_	**************************************	07/	17/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CIT	Y, STATE, ZIP CODE		1772013
WHOLIS	TIC 02		1226 LAV WASHING	VRENCE S	TREET, NE 20017		
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I 401	Continued From page	ge 3		1401		,	
	Professional services and evaluation, includevelopmental level services, and service deterioration or furth resident. This Statute is not represent the services and services and services deterioration or furth resident. This Statute is not represent the services and services are services and services are services and services	es shall include both uding identification or s and needs, treatmes designed to prevener loss of function be met as evidenced by and record review, the with intellectual disasure the timely provised to treat an infection the sample. (Reside	fent ent y the : ne group abilities sion	I 401			
	The findings include: 1. During the verification of the medication administration on July 15, 2013, at 6:53 p.m., review of the medication administration record (MAR) revealed Resident #1 had also received Cipro 500 mg via G-tube twice a day for ten days, which ended on July 10, 2013. The concurrent review of a physician's order dated July 1, 2013, revealed the resident was prescribed the Cipro for a G-tube site infection. The supervisory registered nurse (RN) #1 was interviewed on July 16, 2013, at 2:05 p.m., to ascertain why Resident #1 was prescribed Cipro 500 mg. According to supervisory RN #1, a licensed practical nurse reported that Resident #1's G-tube site had a small amount of drainage on June 18, 2013. On July 16, 2013 at 2:08 p.m., review of a laboratory report confirmed that a culture was obtained on June 18, 2013. The results of the culture were reported on June 21, 2013 and revealed a bacterial growth of pseudomonas aeruginosa. It should be noted that on July 1, 2013 (nine days later), Cipro 500 mg was						

AND PLAN OF CORRECTION (X1) PROVIDER OF CORRECTION (X2) IDENTIFICATION NUMBER: HFD03-0009 NAME OF PROVIDER OR SUPPLIER WHOLISTIC 02 (X3) ID SUMMARY STATEMENT OF DEPICIENCIES (R2A) IDENTIFICATION NUMBER: HFD03-0009 SUMMARY STATEMENT OF DEPICIENCIES (R2A) IDENTIFICATION NUMBER: (R2A) IDENTIFICAT	STATEME	Regulation & Licensir	ng Administration	25				FORM	M APPROVE
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 02 SUMMARY STATEMENT OF DEFICIPACIES (STY, STATE, ZIP CODE 1226 LAWRENCE STREET, NE WASHINGTON, DC 20017 REGULATORY OR LSC IDENTIFYING INFORMATION) I 401 Continued From page 4 prescribed. Further interview with supervisory RN #1 on July 16, 2013, at 2:09 p.m., confirmed Resident #1 did not receive medication to treat the pseudomonas aeruginosa until nine days after the results of the test were obtained by the laboratory. According to supervisory RN #1, the protocol was that the laboratory reports the results of tests directly to the primary care physician. Further discussion with supervisory RN #1, how protocol was that the laboratory results were received. At the time of the survey, the facility failed to provide evidence that timely measures were implemented to address Resident #1's G-tube infection. 2. On July 17, 2013, at 1:25 p.m., review of a nursing progress note dated January 14, 2013 (4:00 p.m.), revealed Resident #2 returned from both eyes. The primary care physician (PCP) was informed and gave a telephone order for Tobradex, 2 drops in both eyes for 7 days; the order was faxed to the pharmacy. On July 17, 2013, at 1:28 p.m., review of a physician's order dated January 14, 2013, confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed that Resident #2 was prescribed Tobradex Opthhalming solution not adopt to each of the confirmed tha	AND PLAI	N OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NO	ER/CLIA JMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	N	(X3) DAT	E SURVEY
WHOLISTIC 02 SIMMARY STATEMENT OF DEFICIENCES (MASHINGTON, DC 20017) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY AULT (EACH DEFICIENCY) I 401 Continued From page 4 Prescribed. Further interview with supervisory RN #1 on July 16, 2013, at 2:09 p.m., confirmed Resident #1 did not receive medication to treat the pseudomonas aeruginosa until nine days after the results of the test were obtained by the laboratory. According to supervisory RN #1, the protocol was that the laboratory reports the results of tests directly to the primary care physician. Further discussion with supervisory RN #1, however indicated she was not informed of the actual date the laboratory results were received. At the time of the survey, the facility failed to provide evidence that timely measures were implemented to address Resident #1's G-tube infection. 2. On July 17, 2013, at 1:25 p.m., review of a nursing progress note dated January 14, 2013 (4:00 p.m.), revealed Resident #2 returned from both eyes. The primary care physician (PCP) was informed and gave a telephone order for Tobradex, 2 drops in both eyes for 7 days; the order was faxed to the pharmacy. On July 17, 2013, at 1:28 p.m., review of a physician's order dated January 14, 2013, confirmed that Resident #2 was prescribed Tobradex Opthilalmits solution, now drop to each to the process of the pharmacy.			HEDO2 0000				/		
## PROVIDENCE OF TREET, NE CA4 ID PROVIDENS PLAN OF CORRECTION PROVIDENCE PLAN OF CORRECTION PROVI	VAME OF	PROVIDER OR SUPPLIER	111-003-0009	STREET A				07/	17/2013
(X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 1401 Continued From page 4 prescribed. Further interview with supervisory RN #1 on July 16, 2013, at 2:09 p.m., confirmed Resident #1 did not receive medication to treat the pseudomonas aeruginosa until nine days after the results of the test were obtained by the laboratory. According to supervisory RN #1, the protocol was that the laboratory reports the results of tests directly to the primary care physician. Further discussion with supervisory RN #1, however indicated she was not informed of the actual date the laboratory results were received. At the time of the survey, the facility failed to provide evidence that timely measures were implemented to address Resident #1's G-tube infection. 2. On July 17, 2013, at 1:25 p.m., review of a nursing progress note dated January 14, 2013 (4:00 p.m.), revealed Resident #2 returned from the day program with purulent discharge from both eyes. The primary care physician (PCP) was informed and gave a telephone order for Tobradex, 2 drops in both eyes for 7 days; the order was faxed to the pharmacy. On July 17, 2013, at 1:28 p.m., review of a physician's order dated January 14, 2013, confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to good to confirmed that Resident #2 was prescribed Tobradex Opthhalmic solution, now drop to good to go	WHOLIS	TIC 02		1226 LA	WRENCE	STREET NE			
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not receive medication to treat the pseudomonas aeruginosa until nine days after the results of the test were obtained by the laboratory. According to supervisory RN #1, the protocol was that the laboratory reports the results of tests directly to the primary care physician. Further discussion with supervisory RN #1, however indicated she was not informed of the actual date the laboratory results were received. At the time of the survey, the facility failed to provide evidence that timely measures were implemented to address Resident #1's G-tube infection. 2. On July 17, 2013, at 1:25 p.m., review of a nursing programs ot dated January 14, 2013 (4:00 p.m.), revealed Resident #2 returned from the day program with purulent discharge from both eyes. The primary care physician (PCP) was informed and gave a telephone order for Tobradex, 2 drops in both eyes for 7 days; the order was faxed to the pharmacy. On July 17, 2013, at 1:28 p.m., review of a physician's order dated January 14, 2013, confirmed that Resident #2 was prescribed Tobradex Ophthalmic solution one drop to rest.		Further interview with	Supervisory PN #4	on luk		Clays to	get full à	esult	11 115
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Tobradex Ophthalmic solution, one drop to cook	Pii	yourding order dated	order dated January 14 2012			to contin	ue to do	end	- 10
	10	pradex Oblitinalmic so	Olution one drop to	each					
eye twice daily for seven days for an eye infection. The corresponding medication	Cyc	twice daily for sever	days for an evo						
administration record however revealed that the	aui	illustration record he	OWEVER revealed the	t the	(acquisit	ion of a	el	
client was not administered the first dosage of Tobradex Ophthalmic solution drops until January 18. 2013 (4 dove letter)	CIIC	in was not administer	red the first dosago	~£			A	40	
18, 2013 (4 days later).	18,	2013 (4 days later).	nation grops until Ja	nuary	1.		for Phan	nard.	
Interview with supervisory RN #1 on July 17,	Inte	rview with supervisor	V RN #1 on July 17		d	nedicat	Hon.		

PRINTED: 07/24/2013 FORM APPROVED

Health Regulation & Licensing Administration						FC	RM APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	PLE CONSTRUCTION	(X3)	DATE SURVEY	
ANDFLAN	MIND I DIN OF CONNECTION I IDENTIFICATION NUMBER.		The second second second	G:	(4.0)	COMPLETED	
					W. Market and M.	ı	
		HFD03-0009		B. WING_			07/17/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		01/11/2013
WHOLIS	TIC 02		1226 LAV WASHING	VRENCE S STON, DC	TREET, NE 20017		
(X4) ID PREFIX TAG				ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		
1 401	Continued From pa	ge 5	30 No. 10	1401			
	A contract of the contract of			1401			3
	having a problem w	revealed Resident#: ith his medical insura	2 was				
	when the medication	n was prescribed, the	erefore				
	the contract pharma	acy did not provide th	e l				
	medication promptly	/. Further discussion	with				
	not receive the initia	confirmed that Resid	ent #2 did				
	drops to treat the int	fection until January	18 2013				
	four day after it was	prescribed.	10, 2010,				×
	At the time of the au						
	At the time of the su provide evidence that	irvey, the facility faile	d to				
	implemented to add	ress Resident #2's e	vere				
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