

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

0037021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 05	STREET ADDRESS, CITY, STATE, ZIP CODE 7128 7TH STREET, NW WASHINGTON, DC 20011
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000

INITIAL COMMENTS

W 000

A recertification and death investigation survey were conducted from January 4, 2010 through January 7, 2010. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a population of five male clients with various levels of mental retardation and disabilities.

The findings of the survey was based on observations at the group home and three day programs, interviews with staff, and the review of clinical and administrative records including incident reports.

On January 2, 2010, Wholistic, Inc. notified the State Agency (SA) via facsimile of the death of Client #6. According to the incident report, Washington Hospital Center (WHC) called Client #6's group home and informed the residential facility that the client had expired. Client #6 had been hospitalized, at the WHC since December 29, 2009.

The State Agency initiated the onsite investigation into Client #6's death, to verify the facility's compliance with federal and state regulatory requirements related to health care management prior to his hospitalization.

Based on the investigative findings pertaining to the death of Client #6, Federal and State licensure deficient practices were identified. As of this date, Health Regulation Administration (HRA) is unable to conclude that the facility's actions or inaction caused or precipitated the death of the client. Upon receipt of the autopsy results, an addendum will be added as appropriate.

*Received 2/4/10*

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

W 130

483.420(a)(7) PROTECTION OF CLIENTS

W 130

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Matto Thomas</i>	TITLE  <i>Vice President</i>	(X6) DATE  <i>2/4/10</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 discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

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

PRINTED: 01/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC DS			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 130	<p>Continued From page 1</p> <p><b>RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each client's right to privacy during care of personal needs, for two of the three clients included in the sample. (Client #2 and #3)</p> <p>The findings include:</p> <p>On January 5, 2010, at approximately 4:00 p.m., Client #3 was observed walking into the bathroom while Client #2 was observed using the toilet.</p> <p>On January 6, 2010, at approximately 4:30 p.m., Client #3 was observed entering the upstairs bathroom while the surveyor was using the facilities. Just before Client #3 entered the bathroom, the surveyor heard the license practical nurse (LPN) say, "no wait" but, Client #3 walked in the bathroom and proceeded to pull his pants down. The surveyor immediately came out the bathroom and observed the LPN standing in the office doorway looking at the registered nurse (RN).</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on January 6, 2010, at approximately 4:35 p.m., revealed that staff should have ensured Clients #2 and #3's privacy.</p> <p>Review of Client #3's occupational therapy</p>	W 130			

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

PRINTED: 01/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011	
(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 130	Continued From page 2 assessment dated September 30, 2009, on January 6, 2010, at approximately 11:33 a.m., revealed the client uses the toilet independently but requires prompting to ensure privacy (closing the door while in the bathroom). Review of Client #3's individual program plan (IPP) revealed no evidence of training in the area of privacy.	W 130	<b>W 130</b> An Individual Program Plan (IPP) goal of enhancing privacy will be put in place for client #3. Staff will implement program goal daily.	02/03/10
W 148	<b>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</b>  The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify family member and/or guardian of an injury of unknown origin, for one client in the investigation. (Client #6 - deceased)  The finding includes:  Review of the Client #6's nursing notes dated December 29, 2009, on January 7, 2010, at approximately 10:00 a.m., revealed that Client #6 had a 2 X 2 inch bruise on his knee. Further review of the nursing note, indicated inquiry was made to the client regarding the bruise on his knee. The client replied, "I don't know how it happened." No swelling was noted. The RN further noted that the Incident Management Coordinator (IMC) was notified, via voice message.  There was no evidence that Client #6's family member (sister) had been notified of the injury.	W 148	<b>W 148</b> Staff will be trained on incident management policies and procedures. Emphasis of the training will be, informing all parties (including the administrator) of an incident.  Training of staff on incident management policies and procedures will be done semi-annually to ensure competence.	02/03/10

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

PRINTED: 01/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 08			STREET ADDRESS, CITY, STATE, ZIP CODE 7128 7TH STREET, NW WASHINGTON, DC 20011		
(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 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of client's records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the administrator and to the State agency, for one of the client included in the investigation. (Client #6)</p> <p>The finding includes:</p> <p>Review of the Client #6's nursing note dated December 29, 2009, on January 7, 2010, at approximately 10:00 a.m., revealed that Client #6 had a 2 X 2 inch bruise on his knee. No swelling was noted. The registered nurse (RN) asked the client how he sustained the bruise on his knee, and he replied, "I don't know." The RN further noted that the Incident Management Coordinator (IMC) was notified, via voice message.</p> <p>An interview was conducted with the RN on January 7, 2009, at beginning at 12:05 p.m., to ascertain information regarding the bruise on Client #6's knee. The RN revealed that the client was weak and did not eat breakfast. She informed the staff that she would come to the facility and assess the client. The RN assessed the client on December 29, 2009, at approximately 11:00 a.m., and noted that there</p>	W 163			

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

PRINTED: 01/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/07/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC 06</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>7128 7TH STREET, NW WASHINGTON, DC 20011</b>		
(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 153	Continued From page 4 was a bruise on the client's right knee. At the time of the assessment, the RN made inquiries to the house manager and staff and they did not provide any information about the bruises on the client. The RN then called the IMC and left a message on her voice mail. Further interview revealed that the IMC is not the administrator.	W 153			
W 154	<b>463.420(d)(3) STAFF TREATMENT OF CLIENTS</b>  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all incidents involving injuries of unknown origin had been thoroughly investigated in accordance with the agencies policies and procedures, for one client included in the investigation. (Client #6)  The finding includes:  Review of Client #6's nursing notes dated December 29, 2009, on January 7, 2010, at approximately 10:00 a.m., revealed that Client #6 had a 2 X 2 inch bruise on his knee. No swelling was noted. The registered nurse (RN) asked the client how he sustained the bruise on his knee, and he replied, "I don't know."  Review of the facility's incident reports on January 4, 2010, at 5:00 p.m., revealed no evidence of the aforementioned incident report. Interview with the RN on January 7, 2010, beginning at 12:09 p.m., indicated that the Incident Management Coordinator (IMC) was notified, via voice message on December 29, 2009, at	W 154	<b>W 153</b> <b>Cross-reference W 148</b>		

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

PRINTED: 01/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011	
(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 154	Continued From page 5 approximately 12:30 p.m.  Interview with the qualified mental retardation professional on January 7, 2010, at approximately 1:00 p.m., revealed that he had spoken with the IMC and was informed that the investigation was still being conducted due to the high volume of incidents.  At the time of the survey, the facility failed to provide evidence that the aforementioned incident was investigated.	W 154	W 154 Staff will be trained on the agency's policies and procedures pertaining to reporting and investigation of incidents.	02/03/10
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to complete the consent forms, for one of three clients in the sample. (Client #1)  The findings include:  Observation on January 4, 2010 at 6:20 p.m., revealed the trained medication employee administered Prozac, Risperdal and Klonopin to Client #1.  Record review on January 5, 2010, at 11:20 a.m., revealed the following medical consent forms:  a. Ativan one hour prior to an ENT appointment dated September 5, 2009.	W 159		

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

PRINTED: 01/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 08			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 6  b. Valium one hour prior to EKG and Chest X-ray appointment dated November 24, 2009.  c. Prozac increased 40 mg by mouth every evening to 40 mg by mouth every morning and 20 mg every evening.  Further review of the consent forms revealed Client #1's guardian signature and two unchecked boxes that stated "I consent to Client #1 above-mentioned medications", and "I do not consent to Client #1 taking the above-mentioned medication."  Interview with the QMRP on January 7, 2010, at approximately 2:30 p.m., revealed that he was responsible for ensuring that the consent forms are completed.	W 159			
W 159	483.430(e)(1) STAFF TRAINING PROGRAM  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, for one of three clients in the sample. (Client #2)  The finding includes:  Observation on January 5, 2010, at approximately 10:30 a.m., revealed Client #2 wearing a wind	W 159	W 159 Moving forward, the QMRP will review all consent forms before they are filed to ensure that they are completely filled (one of the two boxes is checked) and signed.	02/03/10	

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

 PRINTED: 01/25/2010  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 189	Continued From page 7 breaker while exiting the day program. Interview with the day program staff revealed Client #2 was going on a community outing. Further interview indicated Client #2 had a winter coat that he has worn to school during the cold weather. Weather reports for the day indicated a high temperature of 32°F.  Interview with the facility's house manager (HM) on January 5, 2010, at approximately 4:30 p.m., revealed Client #2 did not want to wear a winter coat to school. The HM also stated, "he was walking from the house to the van", therefore Client #2 did not need his winter coat.  There was no evidence presented or on file at the time of survey to substantiate that the facility had taken the measures to ensure Client #2 was trained on how to dress properly according to the weather conditions.	W 189			
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN  The Individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.  This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that each client was taught to protect their privacy during personal care, for one of three clients in the sample. (Client #3)	W 242	W 189 A training goal geared towards enhancing client #3's knowledge of dressing appropriately given the weather condition will be put in place.	02/03/10	

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

PRINTED: 01/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 242	<p>Continued From page 8</p> <p>The findings include:</p> <p>On January 6, 2010, at approximately 4:00 p.m., Client #3 was observed walking into the bathroom while Client #2 was observed using the toilet.</p> <p>On January 6, 2010, at approximately 4:30 p.m., Client #3 was observed entering the upstairs bathroom while the surveyor was using the facilities. Just before Client #3 entered the bathroom, the surveyor heard the license practical nurse (LPN) say, "no wait" but, Client #3 walked in the bathroom and proceeded to pull his pants down. The surveyor immediately came out the bathroom and observed the LPN standing in the office doorway looking at the registered nurse (RN).</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on January 6, 2010, at approximately 4:35 p.m., revealed that staff should have ensured Clients #2 and #3's privacy.</p> <p>Review of Client 3 #'s occupational therapy assessment dated September 30, 2009, on January 6, 2010, at approximately 11:33 a.m., revealed the client uses the toilet independently but requires prompting to ensure privacy (closing the door while in the bathroom). Review of Client #3's individual program plan (IPP) revealed no evidence of training in the area of privacy, while using the restroom.</p>	W 242			
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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</p>	W 249	<p>W 242 Cross-reference W 148</p>		

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

PRINTED: 01/26/2010  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 08			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(04) 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)	(05) COMPLETION DATE	
W 249	<p>Continued From page 9</p> <p>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to implement a client's Behavior Support Plan (BSP), for one of the three clients included in the sample. (Client #1)</p> <p>The findings include:</p> <p>The facility failed to implement Client #1's BSP as written.</p> <p>Observation at the day program on January 5, 2010, at 12:15 p.m., revealed Client #1 flickering his hands several times and jumping up and down in front of his 1:1 support staff's face without intervention. At 4:11 p.m., at the client's home, the client was observed flickering his hands repetitively, jumping up and down and rocking back and forth in front of his 1:1 support staff's face. At 4:26 p.m., the client was walking back and forth while turning the light switch on and off, as other clients participated in their active treatment programs. About a minute later, Client #1 hit the floor with his hands several times without intervention from his 1:1 support staff. While the house manager was sitting in the dining room, she heard Client #1 hitting the floor in the living room and asked him to stop. At 4:33 p.m., the 1:1 staff handed Client #1 a Connect Four game and he pushed it away. At 4:35 p.m., Client #1 sat on the floor and began to hit the floor</p>	W 249			

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

PRINTED: 01/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011	
(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>several times with his hands without intervention.</p> <p>Interview with the 1:1 support staff on January 5, 2010, at approximately 12:01 p.m., revealed that he was trained on Client #1's BSP. Interview with the Qualified Mental Retardation Professional (QMRP) on January 6, 2010, at approximately 2:00 p.m., revealed that all staff were trained on Client #1's BSP. Records verification of the staff in-service revealed Client #1's 1:1 support staff were trained on November 13, 2009.</p> <p>Review of Client #1's BSP dated September 14, 2009, on January 7, 2010, at 10:55 a.m., revealed the client had maladaptive behaviors including self-injurious behaviors, physical aggression, property destruction, temper tantrums, and self-stimulatory behavior (excessive hand waving, jumping up and down and rocking). As a result, staff were required to proactively inform Client #1 five minutes ahead of time when a change of activity or location was going to occur to prevent agitation. Additionally, the plan documented that staff should provide frequent casual verbal praise throughout the day, everyday. Further review of the BSP revealed the following consequences to target behaviors:</p> <p>a. Verbally direct the client to stop the behavior;</p> <p>b. Talk to him and check him in order to determine if he may be experiencing discomfort;</p> <p>c. Redirect the client immediately to an unoccupied area to calm down;</p> <p>d. Provide adaptive activities to engage, such as listening or playing musical instruments, and manipulating objects;</p>	W 249		

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

PRINTED: 01/26/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 08			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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	Continued From page 11  e. Place your hand over his hand to prevent further self-injury, followed by a quick release; and  f. Provide praise as he calms himself.  There was no evidence that the facility implemented Client #1's BSP as instructed.	W 249	<div style="border: 1px solid black; padding: 5px;"> <p>W 249 Staff will be re-trained on client #1's Behavior Support Plan (BSP). The House Manager and QMRP will on a weekly basis observe staff when implementing client #1's BSP to ensure that interventions specified in the BSP are adhered to as outlined.</p> </div>	02/29/10	

PRINTED: 01/25/2010  
FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC DG		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 7TH STREET, NW WASHINGTON, DC 20011		
(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
1000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure and death investigation survey was conducted from January 4, 2010 through January 7, 2010. A random sample of three residents was selected from a population of five male residents with various levels of mental retardation and disabilities.</p> <p>The findings of the survey was based on observations at the group home and three day programs, interviews with staff, and the review of clinical and administrative records including incident reports.</p> <p>On January 2, 2010, Wholistic, Inc. notified the State Agency (SA) via facsimile of the death of Resident #6. According to the incident report, Washington Hospital Center (WHC) called Resident #6's group home and informed the residential facility that the resident had expired. Resident #6 had been hospitalized, at the WHC since December 28, 2009.</p> <p>The State Agency initiated an onsite investigation on January 4, 2010, to verify the facility's compliance with federal and state regulatory requirements related to Resident #6's health care management prior to his hospitalization.</p> <p>Based on the investigative findings pertaining to the death of Resident #6, a few Federal and State licensure deficient practices were identified. As of this date, Health Regulation Administration (HRA) is unable to conclude that the facility's actions or inaction caused or precipitated the death of the resident. Upon receipt of the autopsy results, an addendum will be added as appropriate.</p>	1000		
1022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE	1022		

Health Regulation Administration

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

*Matthew Jones*

TITLE

*Vice President*

DATE

*1/10/10*

STATE FORM

5007

CJB111

If continuation sheet 1 of 7

PRINTED: 01/25/2010  
FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC DS		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 7TH STREET, NW WASHINGTON, DC 20011		
(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 022	Continued From page 1  Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.  This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure each window was supplied with curtains, shades or blinds, for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6)  The finding includes:  On January 7, 2010, approximately 1:00 p.m., an environmental walk-through of the interior of the GHMRP revealed a sheer curtain in the window located in the upstairs bathroom. The neighbors windows was clearly visible when standing in the bathroom. Interview with the house manager acknowledged that the next door neighbors windows was clearly visible while looking through the curtains. Interview with the House Manager (HM) at approximately 1:05 p.m. acknowledged that the bathroom window was without an appropriate cover, to ensure the residents' privacy.	I 022	I 022 The bathroom curtain has been replaced.	02/03/10
I 090	3504.1 HOUSEKEEPING  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observation and interview, the Group	I 090		

PRINTED: 01/25/2010  
FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06		STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 2  Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for six of six residents residing in the facility. (Residents #1, #2, #3, #4, #5 and #6)  The finding includes:  The environmental inspection of the GHMRP was conducted on January 7, 2010, at approximately 1:00 p.m.. The inspection revealed the following:  a. The lint tray in the dryer consumed a thick layer of lint. Interview with the house manager acknowledged that the lint tray is required to be clean after each load.  b. Wires were observed hanging low from the side of the house to the neighbors house posing a safety risk.	I 090	<b>I 090 a</b> A memo reminding staff to remove the lint from the lint tray after use has been posted by the dryer.  The House Manager will on a daily basis (5 days a week) inspect the lint tray to ensure that staff are removing the lint after use. The weekend supervisor will conduct such inspection on the weekends.  <hr/> <b>I 090 b</b> The wires have been removed.	02/03/10
I 206	<b>3509.6 PERSONNEL POLICIES</b>  Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification	I 206	The facility's maintenance division will on a monthly basis conduct environmental audits (internal and external audits) to ensure compliance with regulations.	02/03/10

PRINTED: 01/25/2010  
FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 08		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 7TH STREET, NW WASHINGTON, DC 20011		
(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 206	Continued From page 3 that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for one (1) of the fifteen staff, and one (1) of the eleven consultants.  The finding includes:  Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on January 6, 2010, beginning at 1:15 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for one of the fifteen staff and one of the ten consultants (primary care physician).	I 206	I 206 The staff and the primary care physician have submitted current health certificates.  The House Manager and the administration will on a quarterly basis review personnel folders to ensure that required documents are updated as needed.	01/27/10
I 379	3519.10 EMERGENCIES  In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours of the next work day.  This Statute is not met as evidenced by: Based on interview and record, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator and the State Agency (DOH/HLA), for one resident included in the investigation. (Resident #6)  The finding includes:	I 379		

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06		STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 379	Continued From page 4  Review of the Resident #8's nursing note dated December 29, 2009, on January 7, 2010, at approximately 10:00 a.m., revealed that Resident #8 had a 2 X 2 inch bruise on his knee. No swelling was noted. The registered nurse (RN) asked the resident how he sustained the bruise on his knee, and he replied, "I don't know." The RN further noted that the Incident Management Coordinator (IMC) was notified, via voice message.  An interview was conducted with the RN on January 7, 2009, at beginning at 12:05 p.m., to ascertain information regarding the bruise on Resident #8's knee. The RN revealed that the resident was weak and did not eat breakfast. She informed the staff that she would come to the facility and assess the resident. The RN assessed the resident on December 29, 2009, at approximately 11:00 a.m., and noted that there was a bruise on the resident's right knee. At the time of the assessment, the RN made inquiries to the house manager and staff and they did not provide any information on the bruises on the resident. The RN then called the IMC and left a message on her voice mail. Further interview revealed that the IMC is not the administrator.	I 379	I 379 Cross reference W 148	
I 422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to implement resident's Behavior Support Plan (BSP), for one of the three residents included in the sample. (Resident #1)	I 422		

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06			STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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	
1422	<p>Continued From page 5</p> <p>The findings include:</p> <p>The facility failed to implement Resident #1's BSP as written.</p> <p>Observation at the day program on January 5, 2010, at 12:15 p.m., revealed Resident #1 flickering his hands several times and jumping up and down in front of his 1:1 support staff's face without intervention. At 4:11 p.m., at the resident's home, the resident was observed flickering his hands repetitively, jumping up and down and rocking back and forth in front of his 1:1 support staff's face. At 4:25 p.m., the resident was walking back and forth while turning the light switch on and off, as other residents participated in their active treatment programs. About a minute later, Resident #1 hit the floor with his hands several times without intervention from his 1:1 support staff. While the house manager was sitting in the dining room, she heard Resident #1 hitting the floor in the living room and asked him to stop. At 4:33 p.m., the 1:1 staff handed Resident #1 a Connect Four game and he pushed it away. At 4:35 p.m., Resident #1 sat on the floor and began to hit the floor several times with his hands without intervention.</p> <p>Interview with the 1:1 support staff on January 5, 2010, at approximately 12:01 p.m., he revealed that he was trained on Resident #1's BSP. Interview with the Qualified Mental Retardation Professional (QMRP) on January 6, 2010, at approximately 2:00 p.m., revealed that all staff were trained on Resident #1's BSP. Records verification of the staff in-service revealed Resident #1's 1:1 support staff were trained on November 13, 2009.</p>	1422			



PRINTED: 01/25/2010  
FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2010
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 06		STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011		
(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 licensure survey was conducted from January 4, 2010 through January 7, 2010. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of five male residents with various levels of mental retardation and disabilities.  The findings of the survey were based on observations at the group home and one day program, interviews with residents and staff, and the review of clinical and administrative records including 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 the review of personnel records, the GHMRP ensured criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for all but one out of the fifteen staff employed.  The finding includes:  On January 6, 2010, beginning at 1:18 p.m., review of personnel records revealed that he began employment in August 2009. He had worked in the Virginia from February 2005 through September 2008. There was no	R 125		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Matthew Jones*TITLE  
*Vice President*

(X6) DATE

*2/4/10*

STATE FORM

6888

CJB111

If continuation sheet 1 of 2