

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

PRINTED: 08/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS An recertification survey was conducted from July 20, 2010, through July 22, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five females 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 staff, and the review of clinical and administrative records including incident reports.	W 000	<i>Received DOH-HHS 10/10</i>	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. This STANDARD is not met as evidenced by: Based on interview, and the review of incident reports and client records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the State agency for one of the three clients included in the sample. (Client #5) The finding includes: Review of the facility's incident reports on July 20, 2010, beginning at 9:46 a.m., revealed an incident involving Client #5 dated July 10, 2009. According to the report, the day program staff reported that Client #5 arrived with a bruise on	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. Little Shores</i>	TITLE <i>V. res. Pres. Act</i>	(X6) DATE <i>8/16/10</i>
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153	Continued From page 1 her right forearm. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on July 21, 2010 at approximately 2:00 p.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents of unknown origin should be reported immediately to the State agency. Review of the incident report, however, revealed that the state agency was notified three days after the incident was reported.	W 153	July 10, 2009, the date of the injury to Client #5, was a Friday. Local regulations require 24 hour or next business day reporting. Hence the report was sent on Monday July 13th, 2009 and do not violate reporting requirements.		
W 191	483.430(e)(2) STAFF TRAINING PROGRAM View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular needs. In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as: · Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals, refer to W150); Use of behavioral principles in training	W 191			

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W 191	<p>Continued From page 2</p> <p>interactions between staff and individuals;</p> <ul style="list-style-type: none"> Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures; Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.; Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic self-help skills; and Use of positive behavior intervention programming. <p>§483.430(e)(2) Probes</p> <p>Does the staff training program reflect the basic needs of the individuals served within the program?</p> <p>Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served?</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was</p>	W 191			

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W 191	Continued From page 3 provided training to effectively address the behavioral needs of one of three clients in the sample. (Client #1) The findings include: The facility failed to ensure that the training conducted on June 24, 2010, on strategies identified in Client #1's behavior support plan were consistently implemented. (Cross reference W249)	W 191	See W249		
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, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure client's received continuous active treatment, for three of the three clients included in the sample. (Clients #1, #2 and #3) The findings include: 1. On July 20, 2010, at 6:18 p.m., Client #1 was observed trying to hug the surveyor. The QMRP told her no and asked her to shake the surveyor's hand instead. At 6:55 p.m., Client #1 put her face inches away from the direct support staff and	W 249			

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W 249	<p>Continued From page 5</p> <p>Review of Client #2's individual program plan (IPP) dated August 21, 2009, on July 21, 2010, at 9:18 a.m., revealed a program objective that stated, "given verbal prompts, [the client] will go up and down a flight of stairs two out of two trials every hour at 100% of the trials five times a week for six months."</p> <p>Review of the data collection record on July 21, 2010, at 9:40 a.m., reflected that the client participated in the aforementioned program, however, observations on July 20, 2010, did not reflect PT program as outlined in her IPP. Interview with the QMRP on July 22, 2010, at approximately 10:00 a.m., confirmed that the client should walk up and down the stairs at least two times every hour and confirmed that the PT program was not implemented as written.</p> <p>3. After Client #3 completed her dinner on July 20, 2010, at approximately 6:20 p.m., the direct care staff was observed placing the client's dinner dishes in the kitchen sink. The direct care staff did not encourage the client to participate in dinner clean up. Interview with the staff indicated that the client had a program objective to take her items to the kitchen sink, however she refuses on most occasions.</p> <p>Review of Client #3's IPP dated August 22, 2009, on July 21, 2010, beginning at 12:30 p.m., revealed a program objective which stated, "[the client] will take her plate to the sink after dinner with physical assistance 50% of the trials recorded in six months. On July 2, 2010, at approximately 11:30 a.m., the house manager (HM) confirmed the surveyor's observations.</p> <p>4. The facility failed to ensure an effective system</p>	W 249	<p>Staff have been retrained on client 3's IPP on 8/16/10</p>	8/16/10	

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W 249	<p>Continued From page 6</p> <p>to provide training programs for self-administration, for three of the three clients included in the sample. (Clients #1, #2 and #3)</p> <p>a. During medication administration observation on July 20, 2010, at 8:40 a.m., the medication nurse (MN) was observed preparing, crushing and putting Client #1's medications in applesauce. The MN was further observed sanitizing the client's hand and handing the medication mixture to Client #1. The client was observed to spoon feed herself, independently. The MN filled a cup with water and the client consumed it, requiring verbal prompts.</p> <p>Review of Client #1's Individual Program Plan (IPP) dated July 31, 2009, on July 22, 2010, at 1:30 p.m., revealed upon request from staff to participate in the administration of medication, [the client] will independently perform all tasks 100% of recorded trials. Further review indicated Client #1's self-medication program was outlined as follows:</p> <ul style="list-style-type: none"> - get glass of water; - fill cup up with water; - drink water in cup; - put empty medication cup in trash; and - place cup in sink. <p>There was no evidence that Client #1 was given the opportunity to participate in her self medication program as recommended by the Interdisciplinary Team (IDT).</p> <p>b. During medication observation on July 20, 2010, 8:35 a.m., the (MN) was observed preparing Client #2's medications. Client #2 was observed to use hand sanitizer to cleanse her</p>	W 249	<p>The medication nurse will be trained on all self medication programs to ensure all individuals will have the opportunity to participate in the self medication program recommended by their IDT team.</p>	8/20/10
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W 249	Continued From page 8 participate in the self-medication administration. Review of Client #3's Individual Program Plan (IPP) dated August 22, 2009, on July 21, 2010, at 12:30 p.m., revealed upon request from staff to participate in the administration of medication, [the client] will perform all tasks with the use of verbal reminders during the administration of medications, 100% of recorded trials. Further review indicated Client #3's self-medication program was outlined as follows: - get glass of water from nurse; - drink water in cup; - take prescribed medications; and - put empty med cup in trash. There was no evidence that the facility's MN allowed Client #3 to participate in self medication program.	W 249			
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure that Individual Program Plans (IPP)s were reviewed and revised once the client had successfully completed an objective, for one of the three clients included in the sample. (Client #2)	W 255			

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W 255	<p>Continued From page 9</p> <p>The finding includes:</p> <p>The QMRP failed to revise Client #2's IPP once she met the established criteria.</p> <p>During medication observations on July 20, 2010, at 8:35 a.m., Client #2 was observed received Buspar, Risperdal, Depakote and Cogentin. Interview with the medication nurse (MN) indicated that the client received the psychotropic medications to address her diagnosis of intermittent explosive disorder. Review of the client's physician orders dated July 2010, on July 20, 2010, at 2:45 p.m., confirmed the MN's statement. During the entrance conference on July 20, 2010, beginning at 10:12 a.m., the QMRP indicated that Client #2 had a behavior support plan (BSP) to address her maladaptive behaviors of elopement, physical aggression, self-injurious behaviors, screaming/crying, etc... Review of the client's BSP dated September 8, 2009, confirmed the QMRP's statement. The BSP further indicated that the client would decrease elopment to zero incidents per month for 12 consecutive months.</p> <p>Review of Client #2's Psychologist' quarterly reviews from February 23, 2009, through May 21, 2010, indicated that the client had zero incidents of elopement. Interview with the QMRP on July 21, 2010, at approximately 10:00 a.m., revealed that the client had no incidents of elopement in a "long time." The QMRP further indicated that the client's individual support plan (ISP) is scheduled for August 2010, and she would consult with the Psychologist, at that time.</p>	W 255	<p>BSP has been amended to reflect change accomplished objectives. Case Manager has been notified to Amend ISP.</p>	8/16/10
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE	W 261		

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W 261	<p>Continued From page 10</p> <p>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility reviewed and approved clients Behavior Support Plans (BSP), for one of the three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observations during the medication administration on July 20, 2010, at 8:40 a.m., revealed Client #1 received Seroquel and Ability. During the entrance conference on July 20, 2010, beginning on at 10:12 a.m., the qualified mental retardation professional, licensed practical nurse and house manager revealed that Client #1 received psychotropic medications for her diagnosis of bipolar disorder.</p> <p>Review of the HRC meeting minutes dated from June 2009 through June 2010 was conducted on July 22, 2010, beginning at 9:05 a.m. According to the HRC minutes Client #1's BSP to include psychotropic medications were reviewed and approved on February 2, 2010. Further review of the corresponding signature sheet attached to the</p>	W 261		
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W 261	Continued From page 11 minutes failed to provide evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility.	W 261	Our Community Volunteer for our HRC was unable to attend February's meeting. We have made several attempts to ascertain a substitute volunteer but to no avail. We are continuing our efforts	On-going	
W 262	Interview with the qualified mental retardation professional on July 22, 2010, at approximately 9:30 a.m., confirmed that the HRC meeting on February 2, 2010, did not include a person with no ownership or controlling interest in the facility. 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of three clients in the sample. (Client #1) The finding include: Minutes taken at meetings of the facility's HRC for the period June 2009, through June 2010, were reviewed on July 22, 2010, beginning at 9:05 a.m. Review of Client #1's medical chart on July 21, 2010, beginning at 9:37 a.m., revealed Client #1 papsmear was completed under local anesthesia. Interview with the registered nurse, the qualified mental retardation professional and further record review on July 21, 2010, beginning at 9:37 a.m.,	W 262			

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W 262	Continued From page 12 revealed that Client #1 received the sedation to address her non-compliance prior to the medical appointments. There was no evidence, however, that the HRC reviewed and/or approved the use of sedation for Client #1.	W 262	HRC shall approve all use of sedation when "in the opinion of the Committee invoke risk to clients rights and protection." This committee was of the opinion that since the clinic order the sedation, pursuant to consultation document, the committee had belief that medical doctor ordering sedation assessed risks and benefits	8/26/10
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 verification, the facility's nurse failed to ensure drug administration were administered without error, for one of the five clients residing in the facility. (Clients #1, #2)</p> <p>The findings include:</p> <p>1. On July 20, 2010, at 8:35 a.m., Client #2 was observed receiving her medications. The medications included Buspar, Risperdal, Depakote, Cogentin, Singulair, Ferrous Sulfate, Astelin, Nasonex and Flunisolide. Comparison of the medication administration observation and the client's physician orders (POS) dated July 2010; on July 20, 2010, at 9:30 a.m., revealed in addition to the aforementioned medications, the client was also ordered Multi-Delyn S/F, A/F liquid. Interview with the medication nurse indicated that the Multi-Delyn S/F, A/F liquid was not available in the medication cabinet. Interview with the registered nurse (RN) at approximately 3:00 p.m., revealed that the medication was in the bottom of the medication cabinet. On July 20, 2010, the client did not receive the Multi-Delyn S/F, A/F liquid and was ordered to resume on the</p>	W369	<p>and Coupled with the belief that a Papsmeat was in Client #1's best interest.</p> <p>The medication nurse shall be trained on all aspects of medication administration and ensure that all individuals receive their prescribed medication as stated on the physician orders.</p>	8/20/10

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W 369	Continued From page 13 following morning. 2. On July 20, 2010, at 8:25 a.m., the medication nurse began administering the client's medications. Review of each client's POS dated July 2010, revealed that their medications were to be administered at 7:00 a.m. The first dose of medication was administered to Client #5 at 8:25 a.m., and the last medication was administered to Client #2 at 8:50 a.m. The medication was not within the allotted time frame of one hour before or one hour after the prescribed time. Interview with the licensed practical nurse (LPN) on July 20, 2010, at 10:55 a.m., revealed that the medication administration was scheduled at 7:00 a.m. At that time, the LPN was informed of the medication administration time. Further interview with the RN confirmed that the medications were administered in error. The RN and qualified mental retardation professional followed the agency's medication error policy and completed an incident report.	W 369		
W 381	483.460(I)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the facility's nurse failed to store drugs under the proper conditions of security, during the medication administration, for five of the five clients in the facility. (Clients #1, #2, #3, #4 and #5) The findings include:	W 381		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 381	<p>Continued From page 14</p> <p>1. On July 20, 2010, beginning at 8:20 a.m., the medication nurse was observed to leave the medication closet door unlocked while she went to kitchen to begin administering the client's medications. At 8:26 a.m., the medication nurse left the medication tray on the kitchen counter, unsecured while she took Client #4 to the living room, retrieved Client #5 and brought her into the kitchen. The medication nurse was observed administering Client #5's medication. At 8:30 a.m., the medication nurse went into the dining room to administered Client #3's medications, leaving the medication tray on the kitchen counter, unattended. At 8:33 a.m., the medication nurse left the medication tray on the kitchen counter, unsecured while she took Client #4 to the living. At 8:40 a.m., the medication nurse was observed going into the medication cabinet. At 8:42 a.m., she left the medication cabinet wide opened and retrieved Client #2 from the upstairs. The medication administration was completed at 8:50 a.m.</p> <p>During the medication administration, the clients, the direct care staff, and surveyors were observed in the area while the medications were unsecured. After the medication administration, the medication nurse was informed and acknowledged that the medications were unsecured, during the medication administration.</p>	W 381	<p>The medication nurse will be trained on properly securing all medications at all times.</p>	8/20/10
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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1 000	INITIAL COMMENTS An licensure survey was conducted from July 20, 2010, through July 22, 2010. A random sample of three residents was selected from a population of five females 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 staff, and the review of clinical and administrative records including incident reports.	1 000		
1 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner for five of five residents residing in the facility. (Resident #1, #2, #3, #4 and #5) The findings include: Observation and interview with the facility's operations manager (OM) and manager coordinator (MC) on July 21, 2010, beginning at approximately 9:45 a.m., revealed the following: Exterior:	1 090		

Health Regulation Administration
M. N. Shaw
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: *Vice President* (X6) DATE: *8/16/10*
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I 090	Continued From page 1 1. The front steps had chipping and peeling paint on them and the pillar on the left side is rotten at the bottom. 2. The front walkway had an elevated area, which is considered to be a tripping hazard. 3. On the right side of the front steps there is a large hole in the wall. 4. The front upper roof face board had chipping and peeling paint as well as window ledges on the right and left sides of the house. There is also chipping and peeling paint on the window ledges and upper facial board on the rear of the house. 5. There is wood and trash under the rear porch. 6. The upper railing had splinters protruding from the railing on top. 7. The upper steps in the rear of the house (#2 and #4) were raised which could produce a tripping hazard. 8. The right drain down spout was missing. Interior: 1. The bathroom on the second floor, had an exhaust fan that was not working. 10. Resident #1 and #4's bedroom # 2 had chipped paint on the ceiling. The Operations Manager (OM) and the Manager Coordinator acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	I 090	Front step paint replaced pillar on left side replaced Elevated area has been leveled Hole in wall has been filled Upper roof face board, window ledges at rear and front of home have been repainted and chipped paint removed. Wood and trash removed under rear porch Upper railing has been smoothed. Steps in the rear house have been leveled right drain down spout replaced <u>Interior</u> Exhaust fan in second floor has been fixed Bedroom # 2 has been repainted	7/22/10 7/24/10 7/24/10 7/24/10 7/30/10 7/22/10 7/22/10 7/30/10 7/30/10 7/24/10 7/30/10

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1 186	<p>3508.5(c) ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall have an organization chart that shows the following:</p> <p>(c) The categories and numbers of supportive and direct care staff, and...</p> <p>This Statute is not met as evidenced by: Based on review of the policy and procedures manual, the Group Home for the Mentally Retarded Persons (GHMRP) failed to provide an organizational chart depicting categories and numbers of supportive and direct care staff.</p> <p>The finding includes:</p> <p>Review of the GHMRP's administrative records on July 20, 2010, beginning at 5:45 p.m., revealed that the organization chart failed to list the names and numbers of supportive, direct care staff and trained medication employee.</p>	1 186	<p>TME's have been included on organizational chart.</p>	8/16/10
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1 206	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on personnel record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure current health screening for one of eight</p>	1 206	<p>Consultant Physical has been attained. Please find attached.</p>	8/16/10
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I 206	<p>Continued From page 3</p> <p>consultant staff.</p> <p>The finding includes:</p> <p>During a record review and interview with the Qualified Mental Retardation Professional (QMRP), on July 21, 2010, at approximately 1:30 p.m. revealed the Social Worker did not have a current health screening certificate on file.</p> <p>These findings were acknowledged by the QMRP at the time of the record review.</p>	I 206		
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I 372	<p>3519.3 EMERGENCIES</p> <p>Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator.</p> <p>The finding includes:</p> <p>Observations on July 21, 2010, at 10:30 a.m., revealed there were no emergency phone numbers posted by the telephone in the living room nor by the phone in the basement. Prior to the surveyors leaving, however, the facility's staff posted emergency number by both telephones.</p> <p>This deficiency was acknowledged by the</p>	I 372	<p>Emergency number shall be posted by the phone. Wholistic finds this inconsistent with best practice and the desire to to create homelike environments for the people we support. We ask that HRA consider waiving this regulation as it is outdated an institutional culture in our set settings.</p>	8/16/10
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I 372	Continued From page 4 qualified mental retardation professional on July 22, 2010, at 11:30 a.m.	I 372		
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 or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure injuries of unknown origin were reported immediately to the Department of Health, Health Regulations Licensing Administration (DOH/HRLA), in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for one of the five residents residing in the facility. (Resident #5) The finding includes: Review of the facility's incident reports on July 20, 2010, beginning at 9:46 a.m., revealed an incident involving Resident #5 dated July 10, 2009. According to the report, the day program staff reported that Resident #5 arrived with a bruise on her right forearm. An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on July	I 379	see W153	

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I 379	Continued From page 5 21, 2010, at approximately 2:00 p.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents of unknown origin should be reported immediately to the State agency. Review of the incident report, however, revealed that the state agency was notified three days after the incident was reported.	I 379		
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, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan (IHP), for three of the three residents included in the sample. (Residents #1, #2 and #3) The findings include: 1. Observation on July 20, 2010, at 6:18 p.m., revealed Resident #1 trying to hug the surveyor. The QMRP told her no and asked her to shake the surveyor's hand instead. At 6:55 p.m., Resident #1 put her face inches away from the direct support staff and asked for a hug. The staff said, "No" then turned away. On July 21, 2010, at 10:45 a.m., review of Resident #1's behavior support plan (BSP) dated February 2, 2010, revealed "kissing people and walls, sniffing, and hugging people" were challenging maladaptive behaviors identified in	I 422	See W249	

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I 422	<p>Continued From page 6</p> <p>the BSP. Further review revealed that when Resident #1 displays the aforementioned behaviors, staff is required to calmly verbally prompt the resident to shake hands. Staff should model hand shaking, then verbally direct her to do the same. If the resident complies, then she should be thanked and verbally praised for her compliance.</p> <p>In an interview with the qualified mental retardation professional (QMRP) on July 22, 2010, at 2:00 p.m., she confirmed that the staff was required to shake her hand.</p> <p>2. On July 20, 2010, at 4:48 p.m., the direct care staff was overheard informing Resident #2 that she would be starting her physical therapy (PT) program in five minutes. Interview with the direct care staff at 4:51 p.m., revealed that Resident #2's PT program consisted of walking up and down the stairs, every hour. At 4:52 p.m., Resident #2 was observed walking up and down the stairs. The resident was then observed to ascend the stairs for a second time. After which she retreated to her bedroom. She turned on the radio and sat on the floor. At 5:45 p.m., Resident #2 was observed coming down the stairs and sitting at the dining room table. After the resident completed her meal, at 6:10 p.m., Resident #2 was observed walking up the stairs and remained in her bedroom, until at least 7:10 p.m.</p> <p>Review of Resident #2's individual program plan (IPP) dated August 21, 2009, on July 21, 2010, at 9:18 a.m., revealed a program objective that stated, "given verbal prompts, [the resident] will go up and down a flight of stairs two out of two trials every hour at 100% of the trials five times a week for six months."</p>	I 422	See W249	

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I 424	<p>Continued From page 8</p> <p>Plan;</p> <p>This Statute is not met as evidenced by: Based on staff interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP), Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident had successfully completed an objective identified in the IPP, for one of the two residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>The QMRP failed to revise Resident #2's IPP once she met the established criteria.</p> <p>During medication observations on July 20, 2010, at 8:35 a.m., Resident #2 received Buspar, Risperdal, Depakote and Cogentin. Interview with the medication nurse (MN) indicated that the resident received the psychotropic medications to address her diagnosis of intermittent explosive disorder. Review of the resident's physician orders dated July 20, 2010, on July 20, 2010, at 2:45 p.m., confirmed the MN's statement. During the entrance conference on July 20, 2010, beginning at 10:12 a.m., the QMRP indicated that Resident #2 had a behavior support plan (BSP) to address her maladaptive behaviors of elopement, physical aggression, self-injurious behaviors, screaming/crying, etc... Review of the client's BSP dated September 8, 2009, confirmed the QMRP's statement. The BSP further indicated that the resident would decrease elopement to zero incidents per month for 12 consecutive months.</p> <p>Review of Resident #2's Psychologist' quarterly reviews from February 23, 2009, through May 21,</p>	I 424	<p>See W 255</p>	

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1424	Continued From page 9 2010, indicated that the client had zero incidents of elopement. Interview with the QMRP on July 21, 2010, at approximately 10:00 a.m., revealed that the resident had no incidents of elopement in a "long time." The QMRP further indicated that the resident's individual support plan (ISP) is scheduled for August 2010, and she would consult with the Psychologist, at that time.	1424		
1472	3522.3 MEDICATIONS The physician who identifies the self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation. This Statute is not met as evidenced by: Based on observations, interview and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the monitoring of each residents self medication administration program to make certain residents participated in the training program, for three of three residents in the sample. (Residents #1, #2 and #3) The finding includes: 1. During medication administration observation on July 20, 2010, at 8:40 a.m., the medication nurse (MN) was observed preparing, crushing and putting Resident #1's medications in applesauce. The MN was further observed sanitizing the resident's hand and handing the medication mixture to Resident #1. The resident was observed to spoon feed herself, independently. The MN filled a cup with water and the resident consumed it, requiring verbal prompts.	1472	W 369	

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1472	<p>Continued From page 10</p> <p>Review of Resident #1's Individual Program Plan (IPP) dated July 31, 2009, on July 22, 2010, at 1:30 p.m., revealed upon request from staff to participate in the administration of medication, [the resident] will independently perform all tasks 100% of recorded trials. Further review indicated Resident #1's self-medication program was outlined as follows:</p> <ul style="list-style-type: none"> - get glass of water; - fill cup up with water; - drink water in cup; - put empty medication cup in trash; and - place cup in sink. <p>There was no evidence that Resident #1 was given the opportunity to participate in her self medication program as recommended by the Interdisciplinary Team (IDT).</p> <p>2. During medication observation on July 20, 2010, 8:35 a.m., the (MN) was observed preparing Resident #2's medications. Resident #2 was observed to use hand sanitizer to cleanse her hands with hand over hand assistance from the MN. The MN spoon fed the resident her medications. After three pills, the resident spit the medications out of her mouth. After which, the MN asked the resident if she wanted to take her medications with applesauce. The MN was observed preparing the three pills and spoon feeding the medication to the resident in applesauce. The MN was further observed putting water in a cup and feeding it to the resident. The MN put the empty cup of water in the sink.</p> <p>Review of the self medication assessment dated June 4, 2010, on July 20, 2010, at approximately 4:10 p.m., identified numerous skills that the</p>	1472	W 369	

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1472	<p>Continued From page 11</p> <p>resident lacked. Review of Resident #2's Individual Program Plan (IPP) dated August 21, 2009, on July 20, 2010, at approximately 4:25 p.m., revealed a program objective with the following steps:</p> <ul style="list-style-type: none"> - get cup of water from the nurse; - drink water in cup; - take prescribed medications; and - put empty medication cup in trash. <p>There was no evidence that the facility's MN allowed Resident #2 to participate in self medication as opportunity allowed.</p> <p>3. Observation of the medication administration on July 20, 2010, at 8:30 a.m., revealed the MN preparing Resident #3's medications by punching the medication into the cup and filling a cup with water. The MN was then observed to spoon feed Resident #3's medications by holding the cup up to the resident's mouth as the resident drank the water, and placing the cup into the trash can. At no time did the MN encourage the resident to participate in the self-medication administration.</p> <p>Review of Resident #3's Individual Program Plan (IPP) dated August 22, 2009, on July 21, 2010, at 12:30 p.m., revealed upon request from staff to participate in the administration of medication, [the resident] will perform all tasks with the use of verbal reminders during the administration of medications, 100% of recorded trials. Further review indicated Resident #3's self- medication program was outlined as follows:</p> <ul style="list-style-type: none"> - get glass of water from nurse; - drink water in cup; - take prescribed medications; and - put empty med cup in trash. 	1472		

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If continuation sheet 12 of 16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09		STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012		
(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
1472	Continued From page 12 There was no evidence that the facility's MN allowed Resident #3 to participate in self medication program.	1472		
1473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide evidence its ensure residence director reported irregularities in residents' drug regimens to the prescribing physician, for five of the five residents residing in the facility. (Residents #1, #2, #3, #4, and #5). The findings include: 1. On July 20, 2010, at 8:35 a.m., Resident #2 was observed receiving her medications. The medications included Buspar, Risperdal, Depakote, Cogentin, Singulair, Ferrous Sulfate, Astelin, Nasonex and Flunisolide. Comparison of the medication administration observation and the client's physician orders (POS) dated July 2010, on July 20, 2010, at 9:30 a.m., revealed that the resident was also ordered Multi-Delyn S/F, A/F liquid. Interview with the medication nurse indicated that the Multi-Delyn S/F, A/F liquid was not available in the medication cabinet. Interview with the registered nurse (RN) at approximately 3:00 p.m., revealed that the medication was in the bottom of the medication cabinet. On July 20, 2010, the resident did not receive the Multi-Delyn S/F, A/F liquid and was ordered to resume on the following morning.	1473	<i>Drug regimen irregularities were report to PCP but not until July 24, 2010. Regulations fail to express timeliness of reporting. Director shall ensure that Doctors is notified of irregularities moving forward within 24hrs.</i>	<i>8/16/10</i>

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1473	Continued From page 13 2. On July 20, 2010, at 8:25 a.m., the medication nurse began administering the resident's medications. Review of each resident's POS dated July 2010, revealed that their medications are to be administered at 7:00 a.m. The first dose of medication was administered to Resident #5 at 8:25 a.m., and the last medication was administered to Resident #2 at 8:50 a.m. The medication was not within the allotted time frame of one hour before or one hour after the prescribed time. Interview with the licensed practical nurse (LPN) on July 20, 2010, at 10:55 a.m., revealed that the medication administration was scheduled at 7:00 a.m. At that time, the LPN was informed of the medication administration time. Further interview with the RN confirmed that the medications were administered in error. The RN and qualified mental retardation professional followed the agency's medication error policy and completed an incident report.	1473		
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly	1500	Mother of Client #1 is the DDS approved surrogate decision maker for medical issues. In addition, the staff clinic articulated a desire for sedation in order to complete procedure.	8/16/10

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1500	<p>Continued From page 14</p> <p>called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the three residents included in the sample. (Resident #1)</p> <p>The findings include:</p> <p>1. Minutes taken at meetings of the facility's HRC for the period June 2009, through June 2010, were reviewed on July 22, 2010, beginning at 9:05 a.m. Review of Resident #1's medical chart on July 21, 2010, beginning at 9:37 a.m., revealed Resident #1's pap smear was completed under local anesthesia.</p> <p>Interview with the registered nurse, the qualified mental retardation professional and further record review on July 21, 2010, beginning at 9:37 a.m., revealed that Resident #1 received the sedation to address her non-compliance prior to the medical appointments. There was no evidence, however, that the HRC reviewed and/or approved the use of sedation for Resident #1.</p> <p>2. Observations during the medication administration on July 20, 2010, at 8:40 a.m., revealed Resident #1 received Seroquel and Ability. During the entrance conference on July 20, 2010, beginning on at 10:12 a.m., the qualified mental retardation professional, licensed practical nurse and house manager revealed that Resident #1 received psychotropic medications for her diagnosis of bipolar disorder.</p> <p>Review of the HRC meeting minutes dated from June 2009 through June 2010 was conducted on July 22, 2010, beginning at 9:05 a.m. According to the HRC minutes Resident #1's BSP to include psychotropic medications were reviewed and</p>	1500	<p>Notwithstanding, Provider shall ensure that HRC reviews sedation for all individuals prior to appt's through the tracking of new Electronic Medical Records software. Our PrecisionCare implementation date is October of 2010.</p>	8/16/10

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1500	<p>Continued From page 15</p> <p>approved on February 2, 2010. Further review of the corresponding signature sheet attached to the minutes failed to provide evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility.</p> <p>Interview with the qualified mental retardation professional on July 22, 2010, at approximately 9:30 a.m., confirmed that the HRC meeting on February 2, 2010, did not include a person with no ownership or controlling interest in the facility.</p>	1500		
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