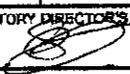


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/25/2011
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G148 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 04/29/2011 |
| NAME OF PROVIDER OR SUPPLIER WHOLISTIC 03 | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017 | |
| (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 A recertification survey was conducted from April 27, 2011, through April 29, 2011. A sample of three clients was selected from a population of three females and two males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. | W 000 | <p><i>Received 6/7/11</i></p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 800 North Capitol St., N.E. Washington, D.C. 20002</p> | |
| W 125 | 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, for four of five clients residing in the facility. (Clients #1, 2, #3, and #4) The finding includes: The facility failed to ensure clients' rights were protected by making certain involved family members and/or legally sanctioned medical | W 125 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE COMPLIANCE SUPERVISOR (X5) DATE 6/6/11

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 125 | <p>Continued From page 1</p> <p>representatives assisted them with making decisions, as evidenced below:</p> <p>On April 27, 2011, at 9:58 a.m., it was observed that an alarm sounded when the surveyor walked near the front door. The licensed practical nurse (LPN) was observed to immediately go to the living room area and disconnect the alarm. Later that evening at 4:11 p.m., the clients arrived home from the day program and were assisted into the facility through the back door. From 4:32 p.m. until the surveyor left the facility, the alarm sounded each time staff were observed to exit the front/back door.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on April 27, 2011, at approximately 4:20 p.m., revealed that the alarm was placed on the door to address Client #5's target behavior of elopement. Further interview with the QIDP revealed that he was unsure if the facility's Human Rights Committee (HRC) had approved the use of the alarm. On April 28, 2011, at 12:00 p.m., review of the HRC minutes revealed that the HRC minutes had approved Client #5's Behavior Support Plan (BSP), which included elopement. Further review of the HRC minutes however, failed to address the approval of the door alarm.</p> <p>On April 28, 2011, at 12:34 p.m., continued interview with the QIDP revealed that he could not say for certain if the clients' legal guardians and/or involved family members had been made aware of the purpose of the door alarms and/or agreed to their use. The QIDP then acknowledged that there was no written documentation available for review to verify that</p> | W 125 | <p>W 125</p> <p>The facility's QIDP will ensure family members, legal guardians and/or surrogate decision makers of four of the five individuals (Clients #1, #2, #3 and #4) residing in facility are informed about the use of door alarm in the facility for client #5. Moving forward, the facility's QIDP will ensure individuals' rights are protected. This will be demonstrated by allowing and involving individuals' family members, legal guardians and/or surrogate decision makers to participate in decision making. Individuals will be informed of any decision made on their behalf. The facility's QIDP will ensure HRC minutes address the approval of the door alarm used in the facility for client #5.</p> | 06/15/11 |

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| W 125 | Continued From page 2 they had been involved. | W 125 | | | |
| W 156 | <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all investigations of unusual incidents were completed within five working days of the incident to ensure the health and safety of its clients. (Clients #1 and #2)</p> <p>The finding includes:</p> <p>The facility failed to ensure the timely completion of all investigations of unusual incidents as evidenced below:</p> <ol style="list-style-type: none"> Record review on April 27, 2011, at 10:05 a.m., revealed Client #1 was transported to the emergency room (ER) on January 7, 2011, due to the licensed practical nurse (LPN) noticing that he was unresponsive to his name and stimuli. A review of the investigative report for this unusual incident revealed it was not completed until January 28, 2011. Record review on April 27, 2011, at 10:33 a.m., revealed Client #3 was transported to the ER on April 27, 2010, for a malfunctioning G-Tube. The report detailed the G-Tube was "draining during feeding" and that Client #3 did not appear to be under any distress. A review of | W 156 | <p>W 156; 1 & 2</p> <p>The QIDP will ensure all investigations of unusual incidents are completed in a timely manner to ensure the health and safety of clients #1 and #3 and the other three individuals (Clients #2, #4 and #5) residing in the facility. Going forward, the facility's QIDP will facilitate completion of unusual incidents investigation report within the timeline by being in constant touch and providing the incident management coordinator with all necessary support documents pertaining to the incident in a timely fashion.</p> | | |

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| W 156 | Continued From page 3 the investigative report for this unusual incident revealed it was not completed until May 12, 2010. | W 156 | | | |
| W 159 | Interview with the QIDP on April 28, 2011, at approximately 10:10 a.m., confirmed there was a lapse in the timely completion of both of the aforementioned investigative reports. The QIDP further stated that lapse was an oversight and would be corrected going forward. 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, interview, and record review, the facility failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for two of the three clients in the sample. (Clients #1 and #2) The finding includes: 1. The facility's QIDP failed to initiate the actions necessary to ensure the timely repair of Client #1's adaptive equipment. [See W436] 2. Observation on April 27, 2011, at 11:56 a.m., revealed Client #1 received and consumed his lunch and was not provided seconds. The meal consisted of mixed veggies, apple juice, mac & cheese, baked chicken, and an 8oz cup of grape juice. The day program staff on duty indicated that his meals are prepared by an outside vendor | W 159 | | | |

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| NAME OF PROVIDER OR SUPPLIER WHOLISTIC D3 | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017 | | |
| (K4) 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) | (K5) COMPLETION DATE | |
| W 159 | <p>Continued From page 4</p> <p>and brought to his day program for him to eat. Observation during snack on the same day at 4:36 p.m. revealed he was provided a small container of vanilla pudding and approximately 8 oz of juice for his snack. Later on in the evening at approximately 6:30 p.m., Client #1 was provided a regular dinner.</p> <p>Record review on April 28, 2011, at 10:02 a.m., revealed Client #1's April 25, 2011, Nutritional Assessment documented he sustained a twelve (12 lbs) pound weight loss between January 2011 and February 2011. The weight loss was due to a hospital stay between the dates of January 7, 2011 and January 31, 2011. Further record review revealed the Nutritionist recommended that the home "offer a second portion at all meals after he finishes his first portion of food."</p> <p>Interview with the QIDP on April 28, 2011, at approximately 11:50 a.m. revealed he was not aware of the recommendation that Client #1 be offered second portions during meals and that he had also not notified the day program of the change.</p> <p>There was no evidence presented or on file at the time of survey to substantiate that either the home or the day program was aware that Client #1 should be offered and/or provided seconds for "all meals" as recommended by the Nutritionist.</p> <p>3. On April 27, 2011, beginning at 11:11 a.m., observations conducted at the day program revealed Client #2 sitting in his custom molded wheelchair listening to soft music with his peers. Two minutes later, day program staff was observed to encourage Client #2 to hold a rain</p> | W 159 | | | |

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| W 159 | <p>Continued From page 5</p> <p>stick. The client held the rain stick with his left arm up pressed up against his body. At 11:24 a.m., day program staff placed a soft red ball into the client's lap and encouraged the client to hold the ball. Client #1 held the ball for approximately 20 seconds before the ball dropped. At 11:34 a.m., staff was again observed to place the rain stick back into the individual's right hand. At 11:44 a.m., Client #1 was holding the red ball in his lap.</p> <p>Interview with the QIDP on April 28, 2011, at 9:40 a.m., revealed Client #2 started his new day program in January 2011. Further interview revealed that Client #2 attended his current day program three days a week. When asked, the QIDP could not tell the surveyor what goals and objectives Client #2 was working on while at the day program. He stated that he had not received the day program's quarterly report.</p> <p>Review of Client #2's Individual support plan (ISP) record on April 28, 2011, at 9:48 p.m., revealed the section entitled day program (DP). The DP section revealed no documented evidence of day program goals and objectives for Client #2. Further review of the ISP record revealed the QIDP monthly progress notes from December 2010 through March 2011 did not address any day program visits and/or progress notes.</p> <p>A telephone interview was conducted with day program's case manager (CM) on April 29, 2011, at 11:40 a.m. The CM provided the surveyor with Client #2's goals/objectives for the day program. Additional interview with the QIDP on April 29, 2011, at approximately 2:20 p.m., revealed that he was scheduled to meet with the QIDP on May</p> | W 159 | <p>W 159</p> <p>1. See W 436</p> <p>2. The facility's RN has faxed Physicians Order Sheet with transcribed Client #1's dietary order and Nutritionist's recommendation made on 04/25/2011 (offer a second portion at all meals after he finishes his first portion of food). Moving forward, the facility's QIDP will ensure recommendations made by the Nutritionist will be implemented. The Nutritionist and the facility's RN will retrain and continue to train staff on a quarterly and as needed basis.</p> | 04/29/11 |

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| WV 159 | Continued From page 8 7, 2011, at the day program to discuss Client #2's progress and overall objectives. 4. Observation during the survey on April 27, 2011, at approximately 4:50 p.m., revealed Client #1 interacting with staff by clapping and smiling whenever someone spoke to him. Staff was also observed offering the client food choices during snack. The client smiled and rocked back and forth in his wheelchair while staff picked one of the two food items that were presented to him. During dinner he was served his meal with standard utensils, plates, and cups. Staff was also observed interacting with him throughout the evening. Record review on April 27, 2011, at 2:22 p.m., revealed Client #1's Speech Language Evaluation (SLE) dated May 2, 2010, recommended that "program staff in Client #1's home labels common items and objects used during daily living activities by providing simple descriptions for the use of the item/object to increase functional vocabulary." Interview with the qualified intellectual disabilities professional (QIDP) on April 28, 2011, at 11:51 a.m., revealed he was not aware of the SLE and also had not implemented any of the recommendations outlined in the SLE. The facility failed to ensure the implementation of Client #1's communication program as recommended by the SLE. | WV 159 | 3. QIDP met with Client # day program and discussed his goals and objectives and overall progress. Goals and objectives were obtained from Client # 2's day program and have been filed in the ISP records. Moving forward, facility QIDP will ensure individuals' goals and objectives and progress notes are obtained on a quarterly basis and filed in their ISP records. 4. The facility's QIDP will ensure Client #1's speech language evaluation recommendations are implemented as specified. Moving forward, the QIDP will ensure Speech language recommendations are implemented or followed upon. This will be done through record review of evaluation completed for each individual residing in the facility. | 05/05/11 | 06/15/11 |
| WV 194 | 483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual | WV 194 | | | |

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| W 194 | <p>Continued From page 7 program plans for each client for whom they are responsible.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff demonstrated competency in implementing a client's feeding protocol, for one of three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>The facility failed to ensure Staff #1 implemented Client #2's Feeding Protocol (FP), as evidenced below:</p> <p>On April 27, 2011, at 2:59 p.m., Client #2 was transported to the dining table in his custom molded wheelchair for lunch. The client appeared to be totally dependent on staff for feeding. At 3:01 p.m., Staff #1 was observed to place the client's lunch on the dining table which consisted of pureed turkey, Swiss cheese, whole wheat bread and mayonnaise, mixed vegetables, and fresh fruit (apples). At 3:05 p.m., Staff #1 was observed to feed Client #2 with his head slightly backwards and slightly to the right throughout the meal. At 3:08 p.m., Staff #1 moved Client #2's head from a slightly backwards to a neutral position to drink his beverage. This occurred throughout the majority of the meal observation. At 3:22 p.m., Client #2 was observed sitting in his wheelchair in the dining room after he consumed 100% of his lunch. At 3:36 p.m., the client was taken to his bedroom. At 3:43 p.m., Client #2 was observed in his hospital bed lying on his back.</p> | W 194 | | | |

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| W 194 | Continued From page 8 Interview with Staff #1 on April 27, 2011, at 3:18 p.m., revealed that Client #2 relied on staff totally for feeding. Further interview revealed that he [client] ate slowly, so you have to give him time to swallow all of his food. Review of Client #2's medical records on April 28, 2011, at approximately 1:35 p.m., revealed a FP dated March 29, 2011. According to the FP, staff were to implement the following technique/instructions: - allow him to remain upright for up to one hour after mealtime; - ensure his [client] head is maintained in a neutral position throughout the meal. A second interview was conducted with Staff #1 on April 29, 2011, at 11:34 a.m. Staff #1 acknowledged that on April 27, 2011, while feeding Client #2, he [staff] did not keep the client's head in a neutral position throughout the meal. He further acknowledged that he did not allow Client #2 to remain upright for at least an hour after he completed his lunch. Interview with the qualified intellectual disabilities professional (QIDP) on April 29, 2011, at approximately 1:00 p.m., revealed that all staff had received training on Client #2's feeding protocol. Review of the in service training records on April 29, 2011, at 1:05 p.m., verified that all staff had received training on Client #2's feeding protocol on February 24, 2011, including Staff #1. Note: It should be noted that less spillage was observed when Staff #1 kept Client #2's head in a neutral position while feeding him. | W 194 | W 194 Staff #1 has been retrained on Client #2's feeding protocol. Facility's RN and QIDP will monitor the facility's direct care staff persons on a regular basis to ensure feeding protocol for Client #2 and other individuals having feeding/mealtime protocol residing in the facility are implemented appropriately. The facility's RN will retrain staff on quarterly and as needed basis to ensure safety of individuals during meals and adequate food intake. | 04/28/11 |
| W 436 | 483.470(g)(2) SPACE AND EQUIPMENT | W 436 | | |

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| W 438 | <p>Continued From page 9</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the timely repair of each client's adaptive equipment, for one of three sampled clients. (Client #1)</p> <p>The finding includes:</p> <p>Observation on April 27, 2011, at 3:20 p.m., revealed staff was having a difficult time tilting back Client #1's wheelchair as he sat in the living room. The qualified intellectual disabilities professional (QIDP) offered assistance and managed to get Client #1's wheelchair to slightly tilt backwards.</p> <p>Record review on April 27, 2011, at 2:37 p.m., revealed the primary care physician (PCP) drafted an order and a letter of medical necessity on March 10, 2011, to have Client #1's wheelchair repaired. The accompanying documentation revealed the following items were in need of repair:</p> <ol style="list-style-type: none"> 1. Replace his bilateral elevating foot rests to assist in properly positioning his feet while seated in his wheelchair. 2. Replaced or properly adjust the tilt cables | W 436 | <p>W 436</p> <p>On 03/10/11, the Facility's QIDP requested from PCP a letter of medical necessity and prescription for routine maintenance/repair of Client #1's Wheelchair.</p> <p>Necessary paperwork was faxed to Rehab Equipment Professionals Inc. (REP) and QIDP called and spoke with REP representative to confirm receipt of paperwork.</p> <p>QIDP was told that REP will send a technician out to check Client #1's wheelchair.</p> <p>However, on 03/23/11, residential provider procured elevating footrests for Client #1's wheelchair.</p> <p>Client #1's Wheelchair has been checked by REP technician and parts needed to be replaced identified.</p> <p>QIDP will follow up with REP to ensure timely replacement of parts.</p> | 03/10/11 | 05/09/11 |

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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 |
| W 436 | <p>Continued From page 10 that operate the recliner system.</p> <p>3. Provided bilateral hip guides to assist him to properly sit his wheelchair to prevent him from sliding forward.</p> <p>4. Tightened his bilateral brakes.</p> <p>Interview with the QIDP on April 28, 2011, at 11:33 a.m., revealed he had not followed up on the PCP's recommendations since they were written. The QIDP indicated he would follow-up on the recommendations to see what he could resolve. On the same day at 11:57 a.m., the QIDP informed the survey team that he had identified a repair company and that the repairs are pending. The QIDP later informed the survey team that he spoke with the new repair company and they were scheduled to visit the facility and assess the wheelchair on May 9, 2011.</p> <p>There was no documented evidence presented on file at the time of survey to reflect timely efforts had been made to secure the repairs to Client #1's wheelchair.</p> | W 436 | Moving forward, the facility's QIDP will ensure efforts are made to follow up on repair orders so as to enhance timely repair of individuals' adaptive equipment (wheelchair) | |

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| R 000 | (INITIAL COMMENTS) A licensure survey was conducted from April 27, 2011, through April 28, 2011. A sample of three residents was selected from a population of three females and two males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident 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 interview and record review, the group for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check, for seven of ten staff employed. (Staffs #1, #2, #3, #4, #5, #6, and #7) The finding includes: Interview with the qualified intellectual disabilities professional (QIDP) and review of the personnel files on April 29, 2011, beginning at 10:03 a.m., revealed the GHPID failed to provide evidence of criminal background checks that disclosed a | R 125 | | |

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TITLE

(X6) DATE

COMPLIANCE SUPERVISOR 6/6/11

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0070 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 04/29/2011 |
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| R 125 | Continued From page 1 seven year listing of all jurisdictions where seven staff worked and/or resided at the time of the survey. For example: a. There was no background conducted for Staff #1 who worked in Washington DC. b. There was no background conducted for Staff #2 who worked in Washington DC. c. There was no background conducted for Staff #3 who worked in Washington DC. d. There was no background conducted for Staff #4 who worked in Washington DC and lived in Toronto Canada. e. There was no background conducted for Staff #5 who worked in Washington DC. g. There was no background conducted for Staff #6 who worked in Washington DC. h. There was no background conducted for Staff #7 who worked in Washington DC. At approximately 1:45 p.m., on April 29, 2011, the surveyor reviewed each of the aforementioned findings listed above with the QIDP. The QIDP acknowledged that criminal background checks were not conducted in all jurisdictions where staff lived and/or worked within the past seven years. | R 125 | Please be advised that the regulations indicated "All jurisdictions where seven staff worked and/or resided at the time of survey." All staff have been re-assess to include where they work. The previous background check include only the residence of the staff. Please find all requisite information attached. The independent investigator was unable to conduct an investigation in Toronto Canada as it is outside of the United States. | 5/29/11 |

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| 1000 | INITIAL COMMENTS A licensure survey was conducted from April 27, 2011, through April 29, 2011. A sample of three residents was selected from a population of three females and two males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. | 1000 | | |
| 1047 | 3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure all residents received their meals in accordance with their nutritional recommendations for one of three sampled residents. (Resident #1) The finding includes: [Reference Federal Deficiency Citation W460] Observation at Resident #1's day program on April 27, 2011, at 11:55 a.m., revealed he received and consumed his lunch and was not provided nor offered a second serving. The day program staff on duty indicated that his meals are prepared by an outside vendor and brought to his day program for him to eat. Observation during | 1047 | | |

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| 1047 | Continued From page 1 snack on the same day at 4:36 p.m. revealed he was provided a small container of vanilla pudding and approximately 8oz of juice or his snack. Later on in the evening at approximately 6:30 p.m. Resident #1 was provided dinner and again was not offered nor provided a second serving. Record review on April 28, 2011, at 10:02 a.m., revealed Resident #1's April 25, 2011, Nutritional Assessment documented he sustained a twelve (12 lbs) pound weight loss between January 2011 and February 2011. The weight loss was due to a hospital stay between the dates of January 7, 2011 and January 31, 2011. Further record review revealed the Nutritionist recommended that the home "offer a second portion at all meals after he finishes his first portion of food." Interview with the Registered Nurse (RN) on April 28, 2011, at 11:48a.m., revealed second portions were supposed to be offered after he had completed his first serving of meals. When asked if the day program knew about this change, she indicated yes. Further interview with the QIDP on the same day at approximately 11:50 revealed he was not aware of the recommendation that Resident #1 be offered second portions during meals and that he had also not notified the day program of the change. There was no evidence presented or on file at the time of survey to substantiate that either the home or the day program was aware that Resident #1 should be offered and/or provided seconds for "all meals" as recommended by the Nutritionist. | 1047 | 1047 The facility's RN has faxed Physicians Order Sheet with transcribed Client #1's dietary order and Nutritionist's recommendation made on 04/25/2011 (offer a second portion at all meals after he finishes his first portion of food). Moving forward, the facility's QIDP will ensure recommendations made by the Nutritionist will be implemented and day program will be notified of any nutritional recommendations in a timely manner. The Nutritionist and the facility's RN will retrain and continue to train staff on a quarterly and as needed basis. | |
| 1055 | 3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of | 1055 | | |

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| 1055 | <p>Continued From page 2</p> <p>proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure all staff were competent in implementing a resident's mealtime feeding protocol for one of the three residents residing in the GHPID. [Resident #2]</p> <p>The finding includes:</p> <p>The GHPID failed to ensure Staff #1 implemented Resident #2's Feeding Protocol (FP), as evidence below:</p> <p>On April 27, 2011, at 2:59 p.m., Resident #2 was transported to the dining table in his custom molded wheelchair for lunch. The resident appeared to be totally dependent on staff for feeding. At 3:01 p.m., Staff #1 was observed to place the resident's lunch on the dining table which consisted of pureed turkey, Swiss cheese, wheat bread and mayonnaise, mixed vegetables, and fresh fruit (apples). Staff #1 immediately began to feed Resident #1 his meal at a fast pace for approximately 45 seconds before slowing down. At 3:05 p.m., Staff #1 was observed to feed Resident #2 with his head slightly backwards and slightly to the right throughout the meal. At 3:08 p.m., Staff #1 moved Resident #2's head from a slightly backwards to a neutral position to drink his beverage. This occurred throughout the majority of the meal observation. At 3:22 p.m., Resident #2 was observed sitting in his wheelchair in the dining room after he consumed 100% of his lunch. At 3:36 p.m., the resident was</p> | 1055 | | |

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| 1056 | Continued From page 3 taken to his bedroom. At 3:43 p.m., Resident #2 was observed in his hospital bed lying on his back. Interview with Staff #1 on April 27, 2011, at 3:18 p.m., revealed that Resident #2 relied on staff totally for feeding. Further interview revealed that he [resident] ate slowly, so you have to give him time to swallow all of his food. Review of Resident #2's medical records on April 28, 2011, at approximately 1:35 p.m., revealed a FP dated March 29, 2011. According to the FP, staff were to implement the following technique/instructions: - allow him to remain upright for up to one hour after mealtime; - ensure his [resident] head is maintained in a neutral position throughout the meal. A second interview was conducted with Staff #1 on April 29, 2011, at 11:34 a.m. Staff #1 acknowledged that on April 27, 2011, while feeding Resident #2, he [staff] did not keep the resident's head in a neutral position throughout the meal. He further acknowledged that he did not allow Resident #2 to remain upright for at least an hour after he completed his lunch. Interview with the qualified intellectual disabilities professional (QIDP) on April 29, 2011, at approximately 1:00 p.m., revealed that all staff had received training on Resident #2's feeding protocol. Review of the in service training records on April 29, 2011, at 1:05 p.m., verified that all staff had received training on Resident #1's feeding protocol on February 24, 2011, including Staff #1. Note: it should be noted that less spillage was observed when Staff #1 kept Resident #2's head | 1055 | 1055 Staff #1 has been retrained on Client #2's feeding protocol. Facility's RN and QIDP will monitor the facility's direct care staff persons on a regular basis to ensure feeding protocol for Client #2 and other individuals having feeding/mealtime protocol residing in the facility are implemented appropriately. The facility's RN will retrain staff on quarterly and as needed basis to ensure safety of individuals during meals and adequate food intake. | 4/29/11 |

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| NAME OF PROVIDER OR SUPPLIER WHOLISTIC 03 | | STREET ADDRESS, CITY, STATE, ZIP CODE 1514 BUNKER HILL ROAD, NE WASHINGTON, DC 20017 | | |
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| 1055 | Continued From page 4 in a neutral position while feeding him. | 1055 | | |
| 1180 | <p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the group for persons with intellectual disabilities (GHPID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for two of the three clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. The GHPID's QIDP failed to initiate the actions necessary to ensure the timely repair of Resident#1's adaptive equipment. [See W436] 2. The GHPID's QIDP failed to ensure Resident#1 received his meals in accordance with their nutritional recommendations. [See W460] 3. On April 27, 2011, beginning at 11:11 a.m., observations conducted at the day program revealed Resident#2 sitting in his custom molded wheelchair listening to soft music with his peers. Two minutes later, day program staff was observed to encourage Resident#2 to hold a rain stick. The resident held the rain stick with his left arm up pressed up against his body. At 11:24 a.m., day program staff placed a soft red ball into the client's lap and encouraged the resident to hold the ball. Resident#1 held the ball for | 1180 | | |

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| 1180 | <p>Continued From page 5</p> <p>approximately 20 seconds before the ball dropped. At 11:34 a.m., staff was again observed to place the rain stick back into the individual's right hand. At 11:44 a.m., Resident#1 was holding the red ball in his lap.</p> <p>Interview with the QIDP on April 28, 2011, at 9:40 a.m., revealed Resident#2 started his new day program in January 2011. Further interview revealed that Resident#2 attended his current day program three days a week. When asked, the QIDP could not tell the surveyor what goals and objectives Resident#2 was working on while at the day program. He stated that he had not received the day program's quarterly report.</p> <p>Review of Resident#2's individual support plan (ISP) record on April 28, 2011, at 9:48 p.m., revealed the section entitled day program (DP). The DP section revealed no documented evidence of day program goals and objectives for Resident#2. Further review of the ISP record revealed the QIDP monthly progress notes from December 2010 through March 2011 did not address any day program visits and/or progress notes.</p> <p>A telephone interview was conducted with day program's case manager (CM) on April 29, 2011, at 11:40 a.m. The CM provided the surveyor with Resident#2's goals/objectives for the day program. Additional interview with the QIDP on April 29, 2011, at approximately 2:20 p.m., revealed that he was scheduled to meet with the QIDP on May 7, 2011, at the day program to discuss Resident#2's progress and overall objectives.</p> <p>5. Observation during the survey on April 27, 2011, TIME revealed Resident#1 interacting</p> | 1180 | <p>1180</p> <ol style="list-style-type: none"> 1. See W436 2. See W460 3. QIDP met with Client # day program and discussed his goals and objectives and overall progress. Goals and objectives were obtained from Client # 2's day program and have been filed in the ISP records. Moving forward, facility QIDP will ensure individuals' goals and objectives and progress notes are obtained on a quarterly basis and filed in their ISP records. 4. The facility's QIDP will ensure Client #1's speech language evaluation recommendations are implemented as specified. Moving forward, the QIDP will ensure Speech language recommendations are implemented or followed upon. This will be done through record review of evaluation completed for each individual residing in the facility. | |

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| 1055 | Continued From page 4 in a neutral position while feeding him. | 1055 | | |
| 1180 | <p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the group for persons with intellectual disabilities (GHPID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored services, for two of the three clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. The GHPID's QIDP failed to initiate the actions necessary to ensure the timely repair of Resident#1's adaptive equipment. [See W436] 2. The GHPID's QIDP failed to ensure Resident#1 received his meals in accordance with their nutritional recommendations. [See W460] 3. On April 27, 2011, beginning at 11:11 a.m., observations conducted at the day program revealed Resident#2 sitting in his custom molded wheelchair listening to soft music with his peers. Two minutes later, day program staff was observed to encourage Resident#2 to hold a rain stick. The resident held the rain stick with his left arm up pressed up against his body. At 11:24 a.m., day program staff placed a soft red ball into the client's lap and encouraged the resident to hold the ball. Resident#1 held the ball for | 1180 | | |

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| I 190 | <p>Continued From page 6</p> <p>with staff by clapping and smiling whenever someone spoke to him. Staff was also observed offering the resident food choices during snack. The resident smiled and rocked back and forth in his wheelchair while staff picked one of the two food items that were presented to him. During dinner he was served his meal with standard utensils, plates, and cups. Staff was also observed interacting with him throughout the evening.</p> <p>Record review on April 27, 2011, at 2:22 p.m., revealed Resident#1's Speech Language Evaluation (SLE) dated May 2, 2010, recommended that "program staff in Resident#1's home labels common items and objects used during daily living activities by providing simple descriptions for the use of the item/object to increase functional vocabulary."</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on April 28, 2011, at 11:51 a.m., revealed he was not aware of the SLE and also had not implemented any of the recommendations outlined in the SLE.</p> <p>The GHPID failed to ensure the implementation of Resident#1's communication program as recommended by the SLE.</p> | I 190 | | |