

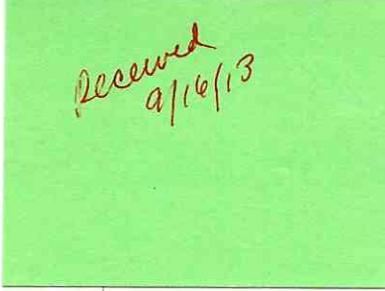
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/06/2013
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 08/28/2013
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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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from August 26, 2013 through August 28, 2013. A sample of two clients was selected from a population of four females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000		
W 362	<p>483.460(j)(1) DRUG REGIMEN REVIEW</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's medication regimen was reviewed by the pharmacist quarterly, for one of two clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>Observations of the medication administration on August 26, 2013, at 6:44 p.m., revealed Client #2 received Clonazepam, Thioridazine and Simvastatin. Review of Client #2's medical record</p>	W 362	<p>RN will review medical books including medication regimen log to ensure quarterly review takes place. all to document in nursing quarterly Review of individual has been completed. See attached</p>	9/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE COMPLIANCE SUPERVISOR	(X6) DATE 9/16/13
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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 362	Continued From page 1 on August 28, 2013, at 12:23 p.m., revealed that the last drug regimen review was conducted on March 5, 2013. (5 months ago) Interview with Registered Nurse (RN) #1 on August 28, 2013, at 3:40 p.m., revealed the pharmacist is required to review the clients drug regimen every quarter. Further interview revealed that she was not aware that the client's drug regimen was not reviewed quarterly by a pharmacist. At the time of the survey, the facility failed to provide evidence that a pharmacist conducted quarterly reviews as required.	W 362		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered in accordance with physician's orders, for two of four clients residing in the facility. (Clients #1 and #2) The findings include: 1. On August 26, 2013, beginning at 6:34 p.m., trained medication employee (TME) #1 began to prepare Client #1's medication. At 6:37 p.m., TME #1 administered Seroquel and Docusate to Client #1. TME #1 indicated that the medication administration was completed for Client #1. TME	W 368	TMEs in the facility have been retrained to ensure correct administration of medication and accurate documentation. RN will observe medication on a regular basis to ensure proper medication administration.	8/30/13

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W 368	<p>Continued From page 2</p> <p>#1 then placed the aforementioned medications in the closet. Review of the medication administration record (MAR) beginning at 8:00 p.m., revealed TME #1 initialed that the Optive eye drops were administered in each eye.</p> <p>On August 26, 2013, at 8:00 p.m., review of the client's medication administration review (MAR) and physician's order sheets (POS) dated August 1, 2013, revealed an order to administer Optive eye drops in each eye twice a day.</p> <p>Interview with TME #1 on August 27, 2013, at 11:10 a.m., revealed she thought she had administered the Optive eye drops with the aforementioned medications.</p> <p>At the time of survey, the facility failed to administer Client #1's Optive eye drops as prescribed.</p> <p>2. On August 26, 2013, at 6:44 p.m., TME #1 administered Clonazepam, Thioridazine and Simvastatin to Client #2. TME #1 then attempted to administer Ketorolac Tromethamine eye drops in her right eye, but the client closed her eyes. Review of the medication administration record (MAR) beginning at 8:00 p.m., revealed TME #1 initialed that the Ketorolac Tromethamine eye drops were administered in the client's right eye.</p> <p>On August 26, 2013, at approximately 8:05 p.m., review of the client's medication administration review (MAR) and physician's order sheets (POS) dated August 1, 2013, revealed an order to administer one drop of Ketorolac Tromethamine eye drops in the right eye four times a day.</p>	W 368		

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W 368	Continued From page 3 Interview with TME #1 on August 27, 2013, at approximately 11:15 a.m., revealed she thought some of the eye drops went into the client's eye. At the time of survey, the facility failed to administer Client #2's Ketorolac Tromethamine eye drops as prescribed.	W 368			
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered without error, for two of four clients residing in the facility. (Clients #1 and #2) The findings include: 1. On August 26, 2013, beginning at 6:34 p.m., trained medication employee (TME) #1 began to prepare Client #1's medication. At 6:37 p.m., TME #1 administered Seroquel and Docusate to Client #1. TME #1 indicated that the medication administration was completed for Client #1. TME #1 then placed the aforementioned medications in the closet. Review of the medication administration record (MAR) beginning at 8:00 p.m., revealed TME #1 initialed that the Optive eye drops were administered in each eye. On August 26, 2013, at 8:00 p.m., review of the client's medication administration review (MAR)	W 369	See W 368		

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W 369	<p>Continued From page 4</p> <p>and physician 's order sheets (POS) dated August 1, 2013, revealed an order to administer Optive eye drops in each eye twice a day.</p> <p>Interview with TME #1 on August 27, 2013, at 11:10 a.m., revealed she thought she had administered the Optive eye drops with the aforementioned medications.</p> <p>At the time of survey, the facility failed to administer Client #1's Optive eye drops as prescribed.</p> <p>2. On August 26, 2013, at 6:44 p.m., TME #1 administered Clonazepam, Thioridazine and Simvastatin to Client #2. TME #1 then attempted to administer Ketorolac Tromethamine eye drops in her right eye, but the client closed her eyes. Review of the medication administration record (MAR) beginning at 8:00 p.m., revealed TME #1 initialed that the Ketorolac Tromethamine eye drops were administered in the client's right eye.</p> <p>On August 26, 2013, at approximately 8:05 p.m., review of the client's medication administration review (MAR) and physician 's order sheets (POS) dated August 1, 2013, revealed an order to administer one drop of Ketorolac Tromethamine eye drops in the right eye four times a day.</p> <p>Interview with TME #1 on August 27, 2013, at approximately 11:15 a.m., revealed she thought some of the eye drops went into the client's eye.</p> <p>At the time of survey, the facility failed to administer Client #2's Ketorolac Tromethamine eye drops as prescribed.</p>	W 369			

Health Regulation & Licensing Administration

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 08/28/2013
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 26, 2013 through August 28, 2013. A sample of two residents was selected from a population of four females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	1 000		
1 473	<p>3522.4 MEDICATIONS</p> <p>The Residence Director shall report any irregularities in the resident 's drug regimens to the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that each resident received medications as prescribed, for one of four residents in the facility. (Resident #2)</p> <p>The finding includes:</p> <p>On August 26, 2013, at 6:44 p.m., TME #1 administered Clonazepam, Thioridazine and Simvastatin to Resident #2. TME #1 then attempted to administer Ketorolac Tromethamine eye drops in her right eye, but the resident closed her eyes. Review of the medication administration</p>	1 473	<p>TMEIS have been retrained on proper and correct medication administration - documentation. Also retrained on informing RN of any irregularities in the drugs regimen. PCP was informed by RN as per nurses notes. See attached</p>	8/24/13

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
COMPLIANCE SUPERVISOR

(X6) DATE
9/10/13

Health Regulation & Licensing Administration

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I 473	<p>Continued From page 1</p> <p>record (MAR) beginning at 8:00 p.m., revealed TME #1 initialed that the Ketorolac Tromethamine eye drops were administered in the resident's right eye.</p> <p>On August 26, 2013, at approximately 8:05 p.m., review of the resident's medication administration review (MAR) and physician 's order sheets (POS) dated August 1, 2013, revealed an order to administer one drop of Ketorolac Tromethamine eye drops in the right eye four times a day.</p> <p>Interview with TME #1 on August 27, 2013, at approximately 11:15 a.m., revealed she thought some of the eye drops went into the resident's eye. Continued interview revealed that the primary care physician was not made aware of the aforementioned findings.</p> <p>At the time of the survey, there was no documented evidence that the irregularity was reported to the PCP.</p>	I 473		