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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G160		04/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	78 53RD PLACE, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from April 23, 2012 through April 25, 2012. A sample of three clients was selected from a population of five men with profound and severe intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and at two day program, interviews with direct support staff and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]		RECEIVED 5/10/12 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients were provided with opportunities for choice and self-management during snack time, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The finding includes: The facility failed to ensure Clients #1, #2, #3, #4, #5 and #6 were afforded opportunities for choice and self-management during snack time, as	W 247	Staff were trained on individual rights and choice making. QIDP and house manager will observe evening activities to ensure that all individuals are given an opportunity to make a choice. 5-7-12	

Floyd Thomas CEO 5-10-12

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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 247	Continued From page 1 evidenced below: On April 23, 2012, at 4:08 p.m., all clients arrived home from the day program. The clients appeared to be non-verbal when greeted. This was later confirmed by the house manager (HM) at 4:18 p.m. At 4:30 p.m, Staff #1 was observed in the kitchen cutting apples and bananas into bite size pieces during snack time. Staff #1 placed the apples and bananas into five different bowls. At 4:33 p.m., Clients #1 and #5 were given bananas. Clients #2, #3 and #4 were given apples. There were no other snacks offered or given by Staff #1. During the environmental walk through on April 25, 2012, at 10:40 a.m., observation of the kitchen revealed there were several other snacks available (i.e. apples, Ritz crackers, Fig Newtons, potatoo chips, etc.). A telephone interview conducted with Staff #1 on April 25, 2012, at 1:15 p.m., revealed that several other snacks were available during snack time on April 23, 2012. Further interview revealed that clients were not given a choice of all available snacks because the clients would choose the snacks not in line with their prescribed diets. Staff #1 went on to say that the clients were more than capable of choosing a snack when presented to them. At the time of the survey, the facility's staff failed to allow clients to exercise their independence and allow options of choice.	W 247		
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	W 249	TME has been retrained on client # 3's self medication program. QIDP will observe medication administrative	5-07-12

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W 249	Continued From page 2 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, interview and record review, the facility failed to ensure continuous active treatment, for one of the three clients in the sample. (Client #3) The finding includes: On April 23, 2012, at 7:34 p.m., observation of the medication administration revealed the trained medication employee (TME) completed all of the steps necessary to provide Client #3 with his medication. The TME was also observed to pour Client #3 a cup water to drink while taking his medications. At no time did the TME encourage the client to participate in the self-medication administration. On April 24, 2012, at 1:44 p.m., review of Client #3's revealed an individual support plan (ISP) dated January 9, 2012, which included a goal to participate in a self-medication program. The ISP stated "that given hand over hand assistance, the client will pour a cup of water prior to taking his evening medications 80% of recorded trials per month. Interview with TME on April 25, 2012, at 9:33 a.m., confirmed that Client #3 had a program to participate during the medication administration	W 249	to ensure that all self medication programs are being implemented accordingly.	

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W 249	Continued From page 3 pass. The TME went on to state that the client's program was not implemented as recommended. At the time of the survey, there was no evidence that the facility implemented Client #3 medication program as recommended.	W 249		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program as recommended by the interdisciplinary team, for one of the three clients in the sample. (Client #3) The finding includes: On April 23, 2012, at 7:34 p.m., observation of the medication administration revealed the trained medication employee (TME) completed all of the steps necessary to provide Client #3 with his medication. The TME was also observed to pour Client #3 a cup water to drink while taking his medications. At no time did the TME encourage the client to participate in the self-medication administration. On April 24, 2012, at 1:44 p.m., review of Client	W 371	Please refer to W249	

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W 371	Continued From page 4 #3's individual support plan (ISP) dated January 9, 2012, revealed the client had a self-medication program. The program revealed that given hand over hand assistance, the client will pour a cup of water prior to taking his evening medications 80% of recorded trials per month. Interview with TME on April 25, 2012, at 9:33 a.m., confirmed that Client #3 had a self-medication program that was to be implemented on April 23, 2012, during the evening medication pass. The TME went on to state that Client #3's self-medication was not implemented as recommended.	W 371		

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	HFD03-0147		04/25/2012

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R 000	INITIAL COMMENTS A licensure survey was conducted from April 23, 2012 through April 25, 2012. A sample of three residents was selected from a population of five men with profound and severe intellectual disabilities. The findings of the survey were based on observations in the home and at two day program, interviews with direct support staff and administrative staff, as well as a review of resident 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 three of the thirteen staff employed. (Staffs #8, #9 and #11) The finding includes: Review of the personnel files on April 25, 2012, beginning at 11:47 a.m., revealed the GHPID failed to provide evidence of criminal background checks that disclosed a seven year history of all	R 125	The facility will continue to conduct background check for all potential employee (s) based on all the states and cities listed on their application prior to the date of hire. Staff # 8, #9, and #11 based on their application never lived or worked in the District of Columbia prior to their date of hire. President 5-10-12	5-4-12

Health Regulation & Licensing Administration

Elena Thomas

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R 125	Continued From page 1 jurisdictions where three staff worked and/or resided at the time of the survey. For example: a. Staff #8 had a background check conducted in the jurisdiction in which he resided (Maryland), but did not have background check conducted where he worked (District of Columbia). b. Staff #9 had a background check conducted in the jurisdiction in which he resided (Maryland), but did not have background check conducted where he worked (District of Columbia). c. Staff #11 had a background check conducted in the jurisdiction in which he resided (Maryland), but did not have background check conducted where he worked (District of Columbia). At approximately 1:00 p.m., on April 25, 2012, the surveyor reviewed the aforementioned finding's listed above with the house manager (HM). The HM verified that criminal background checks were not conducted in all jurisdictions where staff worked within the past seven years.	R 125		

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I 422	Continued From page 1 observed to pour Resident #3 a cup water to drink while taking his medications. At no time did the TME encourage the resident to participate in the self-medication administration. On April 24, 2012, at 1:44 p.m., review of Resident #3's revealed an individual support plan (ISP) dated January 9, 2012, which included a goal to participate in a self-medication program. The ISP stated "that given hand over hand assistance, the resident will pour a cup of water prior to taking his evening medications 80% of recorded trials per month. Interview with TME on April 25, 2012, at 9:33 a.m., confirmed that Resident #3 had a program to participate during the medication administration pass. The TME went on to state that the resident's program was not implemented as recommended. At the time of the survey, there was no evidence that the GHPID implemented Resident #3 medication program as recommended.	I 422		