

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

PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/11/2012
--	---	--	---

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 May 9, 2012, through May 11, 2012. A sampling of three clients was selected from a population of five clients with varying degrees of intellectual disabilities. The 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, and one guardian, as well as a review of the 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.]

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record verification, the qualified intellectual disabilities professional (QIDP) failed to coordinate, integrate, and monitor services, for one of three clients in the sample. (Client #2)

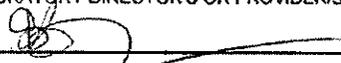
The finding includes:

The QIDP failed to coordinate services to ensure a plan was identified that clearly defined Client #2's use of a gait belt, as evidenced below:

W 000

Received 5/31/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 159

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE COMPLIANCE SUPERVISOR	(X6) DATE 5/31/12
--	---------------------------------------	-----------------------------

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.

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

PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/11/2012
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 159	Continued From page 1 Observation on May 9, 2012, at 5:08 p.m., revealed Client #2 was wearing orthopedic high top shoes and an ankle foot orthosis (AFO) in her right shoe. Staff #2 asked her if she wanted to walk to the basement, however, the client walked with an unsteady gait into the dining room and sat at the table. At 7:18 p.m., the client walked downstairs to the basement with Staff #3. On May 11, 2012, at 9:33 a.m., interview with the QIDP revealed that Client #2 ambulates with a limp, and sometimes uses a gait belt as recommended by the physical therapist to ensure her safety during ambulation. Upon request, the QIDP presented two gait belts which were in good repair. Further discussion with the QIDP revealed that the client wears the gait belt as needed during ambulation. According to the QIDP, there was no written protocol on when the client should wear the gait belt and on how it use should be monitored. The QIDP indicated that the client had a training objective to negotiate the stairs two trips every hour between 4:00 p.m. and 8:00 p.m. daily. Interview with the house manager on May 11, 2011, at 1:39 p.m., revealed that the client wears the gait belt in the facility if she is observed ambulating with an unsteady gait and may wear it when ambulating outside in the community. Further discussion with the home manager indicated that the client's wearing of the gait belt was informal and that no record was required or maintained of when she client wore it. The home manager also indicated that when wearing the gait belt, the client sometimes takes it off and puts it in the bag of items that she like to carry	W 159	

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

PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391

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 05/11/2012	
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 159	<p>Continued From page 2 around.</p> <p>Interview with the day program staff on May 11, 2012, at 11:53 a.m. revealed an expressed concern with the client's safety during ambulation due to her limp and unsteady gait, and her history of uncontrolled seizures. Further discussion with the instructor revealed that the client came to the day program in her wheelchair; however, she had never observed the client with a gait belt.</p> <p>Record review on May 11, 2012, at 9:18 a.m., revealed a physical therapy (PT) progress note dated March 4, 2011 which stated "Consider using a gait belt with handles to assist with ambulation and fall prevention." The review of Client #2 annual physical therapy assessment dated December 27, 2011 on May 11, 2012 at 9:33 a.m., however, revealed no further mentioning of the use of a gait belt. The human rights committee (HRC) minutes dated December 6, 2011 revealed that the continued use of a gait belt for Client #2 was approved.</p> <p>At the time of the survey, there was no evidence services were coordinated and integrated regarding the use of Client #2's gait belt.</p>	W 159	<p>Client #2's physical therapist has developed a protocol on when and how the gait belt should be used. Pls see attached.</p> <p>Protocol has been forwarded to day program to enhance consistency in support.</p> <p>Residential and day programme staff will be trained on protocol.</p> <p>House Manager will monitor staff on a weekly basis to ensure all adaptive equipment is utilized appropriately.</p>	<p>5/29/12</p> <p>5/31/12</p> <p>6/8/12</p> <p>6/8/12</p>

Health Regulation & Licensing Administration

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 05/11/2012
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) COMPLETE DATE
I 000	INITIAL COMMENTS A relicensure survey was conducted from May 9, 2012, through May 11, 2012. A sampling of three residents was selected from a population of five residents with varying degrees of intellectual disabilities. The 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, two day programs, and one guardian, as well as a review of the resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000	
I 165	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on observation interview and record, the facility failed to ensure a policy for disposal of medication. The finding includes: Observation during the administration of Resident #2's medications on May 9, 2012, at 8:03 p.m., revealed that the licensed practical nurse (LPN) #1 poured valproic acid liquid into a clear medication cup. Upon noticing that he had poured more that the prescribed amount of	I 165	

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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

STATE FORM

8899

Q3BW11

If continuation sheet 1 of 4

Health Regulation & Licensing Administration

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 05/11/2012
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) COMPLETE DATE
I 165	<p>Continued From page 1</p> <p>medication in the cup, the LPN transferred 15 ml of the valproic acid into another cup to administer to the resident. LPN #1 was then observed to discard the cup containing the excess valproic acid into the trash can in the office.</p> <p>On May 9, 2012, at 8:09 p.m., LPN #1 was interviewed concerning the observed method of medication disposal. LPN #1 verbalized that it was the usual procedure for disposable of poured liquid medication.</p> <p>On May 11, 2012, at 2:05 p.m., the surveyor requested a copy of the facility's policy on disposal of liquid medication, however, none was presented for review. Discussion with the registered nurse (RN) on May 11, 2012, at 2:17 p.m., acknowledged that her review of the available policies and procedures revealed none were available to provide direction on how to dispose of poured medications. The RN stated that she would further check with the administrative office to verify if there was a written policy to address the disposal of liquid medications during such situations.</p> <p>At the time of the survey, there was no evidence that the facility had established a comprehensive policy on medication disposal.</p>	I 165	<p>Comprehensive policy on medical disposal was 5/17/12 updated. Pls see attach.</p> <p>RN will train all LPNs on medication disposal 6/8/12 policies and procedures.</p> <p>RN will train LPNs on medication administration and disposal guidelines on a quarterly basis. 6/8/12</p>
I 180	<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 verification, the group home for persons with</p>	I 180	

Health Regulation & Licensing Administration

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 05/11/2012
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) COMPLETE DATE
I 180	Continued From page 2 intellectual disabilities (GHPID) failed to provide adequate administrative support to efficiently meet the needs of the residents in accordance with the habilitation plans, for one of three residents in the sample. (Resident #2) The finding includes: The QIDP failed to coordinate services to ensure a plan was identified that clearly defined Resident #2's use of a gait belt, as evidenced below:	I 180	
	<p>Observation on May 9, 2012, at 5:08 p.m., revealed Resident #2 was wearing orthopedic high top shoes and an ankle foot orthosis (AFO) in her right shoe. Staff #2 asked her if she wanted to walk to the basement, however, the resident walked with an unsteady gait into the dining room and sat at the table. At 7:18 p.m., the resident walked downstairs to the basement with Staff #3.</p> <p>On May 11, 2012, at 9:33 a.m., interview with the QIDP revealed that Resident #2 ambulates with a limp, and sometimes uses a gait belt as recommended by the physical therapist to ensure her safety during ambulation. Upon request, the QIDP presented two gait belts which were in good repair. Further discussion with the QIDP revealed that the resident wears the gait belt as needed during ambulation. According to the QIDP, there was no written protocol on when the resident should wear the gait belt and on how it use should be monitored. The QIDP indicated that the resident had a training objective to negotiate the stairs two trips every hour between 4:00 p.m. and 8:00 p.m. daily.</p> <p>Interview with the house manager on May 11, 2011, at 1:39 p.m., revealed that the resident</p>		

Health Regulation & Licensing Administration

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 05/11/2012
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) COMPLETE DATE
I 180	Continued From page 3 wears the gait belt in the facility if she is observed ambulating with an unsteady gait and may wear it when ambulating outside in the community. Further discussion with the home manager indicated that the resident's wearing of the gait belt was informal and that no record was required or maintained of when she resident wore it. The home manager also indicated that when wearing the gait belt, the resident sometimes takes it off and puts it in the bag of items that she like to carry around. Interview with the day program staff on May 11, 2012, at 11:53 a.m. revealed an expressed concern with the resident's safety during ambulation due to her limp and unsteady gait, and her history of uncontrolled seizures. Further discussion with the instructor revealed that the resident came to the day program in her wheelchair; however, she had never observed the resident with a gait belt. Record review on May 11, 2012, at 9:18 a.m., revealed a physical therapy (PT) progress note dated March 4, 2011 which stated "Consider using a gait belt with handles to assist with ambulation and fall prevention." The review of Resident #2 annual physical therapy assessment dated December 27, 2011 on May 11, 2012 at 9:33 a.m., however, revealed no further mentioning of the use of a gait belt. The human rights committee (HRC) minutes dated December 6, 2011 revealed that the continued use of a gait belt for Resident #2 was approved. At the time of the survey, there was no evidence services were coordinated and integrated regarding the use of Resident #2's gait belt.	I 180	See w 159	