

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

PRINTED: 05/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/26/2013
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 04			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, 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	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from April 24, 2013 through April 26, 2013. A sample of three clients was selected from a population of two males and three 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 three day programs, interviews with direct support staff, nursing, and administrative staff, and one guardian, as well as a review of client and administrative records, including incident reports. No federal deficiencies were cited.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	W 000	<p><i>Received 5/10/13</i></p> <p>Department of Health Health Regulation &amp; Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	

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



TITLE

COMPLIANCE SUPERVISOR 5/9/13

(X6) DATE

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.

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/26/2013
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from April 24, 2013 through April 26, 2013.</p> <p>A sample of three residents was selected from a population of two males and three females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and three day programs, interviews with direct support staff, nursing, and administrative staff, and one guardian, 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>	1 000		
1 090	<p><b>3504.1 HOUSEKEEPING</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the group home for individuals with intellectual disabilities (GHIID) failed to maintain the environment in accordance with the needs of five of five residents in the facility. (Residents #1, #2, #3, #4 and #5)</p> <p>The findings include:</p> <p>Observations of the environment were conducted on April 26, 2013, beginning at 10 50 a.m. The</p>	1 090		

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STATE FORM

6899

PIJ511

If continuation sheet 1 of 2

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  04/26/2013
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 04		STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017		
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I 090	Continued From page 1  house manager (HM), qualified intellectual disabilities professional (QIDP), and the operations manager (OM) were present during the inspection and confirmed the findings.  A. The Teflon coating on the interior of the pots used for cooking was heavily chipped, causing the metal underneath to be exposed.  B. The bottom drawer of Resident #2's storage chest was broken.  C. Heavily scaling paint was observed on the right side of the house, near the roof.  D. A large chipped area was observed at the end of the floor board located above the top step leading to the patio.  E. Several of the hand rails on the ramp were warped, which prevented them from being even with the adjacent sections. A splintered area approximately two feet in length was observed on the outside of one of the hand railings.	I 090	Pots will be replaced by 5/13/13  Drawer has been repaired  Scaling and painting scheduled for 5/13/13 weather permitting Chipped area has been repaired  Handrails have been repaired  HM and facilities manager will continue to conduct regular environmental audits to ensure facilities are maintained as mandated	5/13/13  4/26/13  5/13/13  4/26/13  5/8/13