

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

PRINTED: 02/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05	STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS A recertification survey was conducted from January 13, 2010 through January 15, 2010. The survey was initiated using the fundamental survey process. A random sampling of two clients was selected from a client population of four males with various disabilities. The findings of the survey were based on observations in the home and one day programs, interviews with staff in the home and at the day programs, as well as a review of the clinical, administrative, and habilitation records, including a review of the unusual incident/investigation reports.	W 000	<p><i>Renewed 3/3/10</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 104	463.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's governing body failed to provide general operating directions as evidenced below: The findings include: The facility failed to implement an effective system for the maintenance of the dryer system for four of the four clients residing in the facility (Clients #1, #2, #3, and #4), as evidenced below: Observation on January 15, 2010, at approximately 1:40 p.m., revealed the screen in the dryer had a large hole in it and that the screen was detached from the frame on one side. Lint	W 104		<p>W 104 The entire dryer system was removed and a new dryer system was installed. Also, lint found accumulated at the bottom of the window and in the end of the duct attached to the dryer vent was removed and vent cleaned. Wholistic Services, Inc will be conducting regular environmental inspections as specified in the facility's policy on "Repairs and Maintenance", section 3 b. to ensure compliance.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Glenn Thomas* TITLE: *President 3-1-010* (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.

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W 104	<p>Continued From page 1</p> <p>was observed accumulating inside the receptacle where the filter was inserted into the dryer.</p> <p>On the same day at 2:15 p.m., observations of the exterior area of facility where the dryer vent exited the building, revealed it was secured by a gate. Maintenance staff provided entry to this area where there was an accumulation of tall dead weeds. Some of the weeds were broken down by maintenance to provide access to the the dryer vent area. Inspection of the dryer vent area revealed a heavy accumulation of lint several inches thick across the bottom of the window, which appeared to have come from the dryer. An accumulation of lint was also observed in the end of the duct where it was attached to the dryer vent. A large accumulation of lint was also observed on the ground below the window.</p> <p>During interview with the Register Nurse (RN) at the group home on January 15, 2010, at 2:40 p.m., the RN informed the surveyor that upon learning of the lint accumulation (approximately 2:35 p.m.), she immediately telephoned the administrator to inform her of the situation. Upon inspection of the dryer, the duct and vent system, and maintenance staff was observed to remove the aforementioned lint. Interview with the maintenance supervisor indicated that he had been instructed by management to purchase a new lint filter, and if it was not available, to purchase a new dryer. On January 15, 2010, at 4:20 p.m. further observation of the laundry area in the basement revealed a new dryer and duct system had been installed. Inspection of the dryer vent revealed it had been cleaned and attached to a newly installed duct. Inspection of the dryer revealed it was attached to the duct and when turned on, it appeared to operate properly.</p>	W 104	<p>W 104</p> <p>The weeds seen on the side of the facility where the dryer vent is have been cut.</p>	01/18/10	

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W 104	Continued From page 2			W 104			
	<p>Interview with the residential manager on January 15, 2010, at 4:47 p.m. revealed that an internal environmental inspection of the group home was to be conducted on a regular basis. Review of the facility's policy on "Repairs and Maintenance," section 3b revealed, "Preventive maintenance will be conducted daily, weekly, monthly, quarterly, semi-annually or annually in an effort to maintain facility and environmental safety." At the time of the survey, there was no evidence the policy on repairs and maintenance had been effectively implemented, as required to prevent the aforementioned heavy accumulation of lint.</p>				<p>W 104. 2. Cross refer to W 159</p>		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services, for one of the three clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>1. The facility's QMRP failed to coordinate services with the interdisciplinary team (IDT) to</p>			W 159			

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W 159	<p>Continued From page 3</p> <p>determine how Client #1's safety needs were to be addressed when he addressed when he was in bed as evidenced below:</p> <p>a. On January 14, 2010, at 11:25 a.m., the review of an unusual incident report dated January 16, 2009, at 12:02 a.m., staff reported that Client #1 was getting down off his bed and fell on the floor. The incident report further revealed that "staff tried to help [Client #1] but he was already on the floor. He sustained an abrasion on his head above his left eye, above the eyebrow."</p> <p>b. Interview with the registered nurse (RN) on January 15, 2010, at 12:10 p.m. revealed client safety concerns are reviewed by the Human Rights Committee (HRC). The HRC minutes dated February 11, 2009, revealed Client #1 requires one on one staffing in his group home. "Recommendation of the team: Continue to monitor; continue one-on-one". The HRC minutes also included recommendations to (1) continue the use of a hospital bed with rails for safety and (2) continued to wear the prescribed helmet helmet for protection.</p> <p>Additional interview with the RN on January 15, 2010, at 1:30 p.m. revealed that at the time of the HRC (February 11, 2009) recommendation, Client #1 already had a hospital bed with rails. The medical/habilitation records, however, failed to provide specific instructions on how the hospital bed was to be used for the client. Record review also failed to reveal a current physician's order for Client #1 to have a hospital bed. (Note: On January 15, 2010 at 2:30 p.m., one of the pins required to secure the bed rail in an upright position was difficult to engage.)</p>	W 159	<p>W 159. 1.</p> <p>a. QMRP will ensure that 1 of 2 night staff is assigned to Client #1's bedroom to regularly check on him while in bed sleeping.</p> <p>b. The Physical Therapist will do an assessment with client #1 in bed to determine whether to continue the use of hospital bed with rails or not. Findings will be presented to the IDT and HRC.</p> <p>Bedrail on Client #1's bed has been replaced.</p>	03/20/10 03/20/10 01/18/10

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W 159	Continued From page 4 At the time of the survey, there was no evidence the QMRP had coordinated with the IDT to determine how the hospital bed with rails was to be used for Client #1. 2. The QMRP failed to coordinate with the interdisciplinary team to clearly identify Client #1's level of required supervision as evidenced below: a. On January 15, 2010, at 12:45 p.m., review of the psychological assessment dated February 4, 2009, recommended one on one supervision to decrease the frequency of his maladaptive behaviors and unsteady gait due to his tendency to lean forward during ambulation. Record revealed that the number of hours the client was to be provided the one on one supervision was not specified in the psychological assessment. b. On January 15, 2010, at 12:27 p.m., review of the HRC minutes dated February 11, 2009, revealed Client #1 requires one on one staffing in his group home. "Recommendation of the team: Continue to monitor; continue one-on-one" staffing in his group home. Record revealed that the number of hours the client was to be provided the one on one supervision was not specified in the minutes. c. Interview with the QMRP and the RN on January 15, 2010, at approximately 12:30 p.m. on revealed that the funding agency had approved 16 hours of one on one supervision for the Client #1. d. On January 15, 2010, at approximately one on one 12:47 p.m., review of the physical therapy	W 159	W 159. 2. a. The number of hours Client # 1 is to be provided with One-on-one supervision has been included in his current Annual Psychological Assessment. b. The facility's QMRP will ensure that the number of hours Client # 1 is to be provided with One-on-one supervision is included in HRC minutes.	02/03/10 03/02/10	

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W 159	Continued From page 5 (PT) evaluation dated February 6, 2009, revealed precautions for "Falls risk due to visual impairment; he requires one on one staffing 16 hours a day for added safety." The PT evaluation further noted "...has 1: 1 staffing 16 hours a day due to his behaviors, as well as for his safety. He is on a compliance program for his helmet, but so far he has been non-compliant. The helmet is to be used for safety." At the time of the survey, there was no evidence that the QMRP had coordinated with the interdisciplinary team to determine when, and if, the one on one supervision which was approved and recommended by the HRC on February 11, 2009 would be implemented.	W 159	W 159 d. Client #1 had 16 hours One-on-one supervision prior to the HRC meeting on 02/11/09 and the IDT is well aware of the one-on-one service as documented in his ISP.		
W 190	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' developmental needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure training to enable each staff to effectively demonstrate competency toward the specific developmental needs of one of two clients in the sample.(Client #2) The finding includes: Observation on January 14, 2010, at 4:03 p.m. revealed a facility direct care staff instructing Client #2 to go to the bathroom. At 4:12 p.m., the direct care staff pointed to the bathroom and told Client #2 to wash his hands. The client walked into the bathroom and walked right out. The direct	W 190			

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W 190	<p>Continued From page 6</p> <p>care staff pointed to the bathroom and stated, "Go wash your hands". At 4:15 p.m., the house manager told Client #2 to go into the kitchen to help prepare snacks. Further observations revealed staff talking to Client #2 without the use a communication device.</p> <p>Interview revealed the aforementioned staff on January 15, 2010, at 4:35 p.m. determined she did not know how to sign eat, more, water and bathroom. Additional interview with the direct care staff revealed Client #2 had a communication device which he used after dinner.</p> <p>Review of Client #2's speech evaluation dated June 21, 2009, on January 14, 2010, at approximately 5:00 p.m., revealed Client #2 participates in a communication program to utilize a low tech communication device to facilitate his communication with persons in the environment. Further review revealed his communication device with voice output allows him to scan pictures horizontally, vertically and diagonally depress a cell which correlates pictures with basic fundamental wants and needs during communicative acts. Review of the client's acquisition program revealed the client and the staff will use manual signs to express basic wants and needs such as eat, more, water, bathroom, yes and no.</p> <p>The review of the training records on January 15, 2010, at 10:30 a.m., revealed that staff was trained on Client #2's communication program on October 14, 2009. There was no evidence, however, that the provided training was effective to improve the staff's communication with the client.</p>	W 190	<p>W 190</p> <p>The facility's QMRP has retrained staff on the effective use of Client #2's communication device and use of manual signs (eat, drink, more, water, finish, bathroom yes and no) to enhance better communication with Client #2 to meet his specific developmental needs.</p>	01/21/10	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM	W 192			

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W 192	<p>Continued From page 7</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure employees who work with clients, were trained on skills and competencies directed toward clients' health needs, for two of four clients residing in the facility. (Client #1 and #3)</p> <p>The finding includes:</p> <p>[Cross refer to W369] The facility failed to ensure the staff were effectively trained to administer prescribed medications for Clients #1 and #3.</p>	W 192	<p>W 192 Cross refer to W 369</p>	
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active 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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of two clients in the sample. (Client #1)</p>	W 249		

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W 249	<p>Continued From page 8</p> <p>The finding includes:</p> <p>The facility failed to ensure interventions identified in Client #2's behavior support plan were consistently implemented as evidenced below.</p> <p>On January 13, 2010, at 6:30 p.m., Client #1 was observed leaning forward as he was directly assisted by staff when walking about in the group home. During this time, staff indicated the client was required one on one supervision from 8:00 a.m. to 12:00 a.m., to ensure his safety during ambulation.</p> <p>On on January 14, 2010, at 9:45 a.m., interview with the qualified mental retardation professional (QMRP) and the registered (RN) revealed that the funding agency had approved 16 hours (8:00 a.m. to 12:00 a.m.) of one on one supervision for Client #1. The QMRP, however, stated that the client was provided one on one supervision, beginning from the time he got out of bed in the mornings to ensure his safety.</p> <p>On January 14, 2010, at 12:00 p.m., the review of an unusual incident report dated June 12, 2009 (8:05 a.m.), revealed Client #1's one on one staff left him in the living room while he went to "punch in". Upon the one on one's return to the area, he saw [Client#1] "on the floor. He was bleeding from a laceration he had sustained on the bottom of left eye." Further review of the incident report and investigative statements revealed that no one had observed how the client got on the floor.</p> <p>The review of the Client #1's psychological assessment dated February 4, 2009 revealed one</p>	W 249	<p>W 249</p> <p>The facility's QMRP will retrain staff on the implementation of Client # 1's Behavior Support Plan (BSP) and one-on-one guidelines. QMRP and House manager will monitor staff regularly to ensure the interventions specified in the Client #1's BSP are being implemented and also one-on-one guidelines are adhered to.</p>	03/12/10
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W 249	<p>Continued From page 9</p> <p>on one supervision was recommended to decrease the frequency of his maladaptive behaviors, unsteady gait and his tendency to lean forward during ambulation.</p> <p>On January 15, 2010, at 12:13 p.m., the "One-on-One Staff Guidelines... as of January 26, 2009" were reviewed and provided the following information:</p> <p>a. One on one Staff must closely monitor the client "at all times."</p> <p>b. "One-on-One Staff must remain no further than arm's length from the client."</p> <p>c. One-on-one staff must be familiar with the client's BSP (behaviors, proactive and intervention strategies).</p> <p>On January 15, 2010, at 1:27 p.m., the review of Client #1's behavior support plan (BSP) dated March 5, 2009, revealed he "requires one on one staffing in his group home to ensure his physical safety while ambulating from one room to another, due to his unsteady gait and his tendency to lean forward while walking. Within the group home, his behaviors also warrant the use of one on one staffing." The BSP further noted that the client's "maladaptive behaviors, (such as falling to the floor) may be attention-seeking in nature.."</p> <p>At the time of the survey, there was no evidence that Client #1's BSP had been consistently implemented as recommended and approved by the interdisciplinary team to prevent his fall. (See also W159)</p>	W 249		
W 331	483.480(c) NURSING SERVICES	W 331		

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W 331	<p>Continued From page 10</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with the needs two of the four clients residing in the facility. (Client#1 and #3)</p> <p>The findings include:</p> <p>1. [Cross refer to W369] .The facility nursing staff failed to assure that all drugs are administered in compliance with the physician's orders, for Client # 1 and #3.</p> <p>2. The facility's nursing service failed to ascertain how and when Client #1's bed rails were to be used as evidenced below:</p> <p>Interview with the RN on January 15, 2010, at 12:10 p.m. revealed client safety concerns are reviewed by the Human Rights Committee. The review of the HRC minutes dated February 11, 2009, on January 15, 2010, at 12:10 p.m. a revealed a recommendation to continue the approval that the client wear a helmet and have a hospital bed with rails for safety. Additional interview with the RN on January 15, 2010, at 1:30 p.m. revealed that at the time of the HRC (February 11, 2009) recommendation, Client #1 already had a hospital bed with rails. The January 2010 physician's orders, however did not include the hospital bed as a treatment order. Additionally, the review of the available records</p>	W 331	<p>W 331 Cross reference to W 369</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05			STREET ADDRESS, CITY, STATE, ZIP CODE 6827 1ST STREET, NW WASHINGTON, DC 20012		
(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 331	Continued From page 11 during the survey revealed that a past order the the client to use a hospital bed was not available. Observation of the Client #1's bed on January 15, 2010, at 2:30 p.m., revealed one of the pins required to secure the bed rail in an upright position was difficult to engage. The RN indicated that staff had notified her earlier that day of the concern identified with the bed rail. The nurse indicated that a immediate request would be made to have the bed repaired. At the time of the survey, however, there was on evidence that the interdisciplinary team had determined when and how the bed rails were to be used for the client.	W 331	W 331. 2. The Physical Therapist will do an assessment with client #1 in bed to determine whether to continue the use of hospital bed with rails or not. Findings will be presented to the IDT and HRC.	03/20/10	
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 assure that all drugs are administered in compliance with the physician's orders, for two of four clients residing in the facility. (Client # 1 and #3) The finding includes: 1. The facility failed to ensure each of Client #3's medications were administered as prescribed as evidenced below: a. On January 13, 2010, Client #3 was observed to finish eating his dinner meal at 6:20 p.m. At 7:14 p.m., the Trained Medication Employee (TME) administered the client his evening medications. The review of the medications cards	W 369			

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

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W 369	<p>Continued From page 12 from which the medications were punched revealed orders for the following:</p> <p>a. Dilantin Chewable 50 mg (2 tabs), 100 mg BID (7 a.m. and 7 p.m.)</p> <p>b. Calcium w/Vit. D 600 mg-400 tablet, 1 tab twice daily with meals to prevent bone loss. (9 a.m. and 5 p.m.)</p> <p>During the medication administration, the TME revealed that the Dilantin was prescribed for seizures and that the Calcium was prescribed to prevent bone loss.</p> <p>Review of the January 2010 medication administration record (MAR) on January 13, 2010, after the medication administration revealed a handwritten note by the nurse which stated, ".....Remember, calcium should be administered at least two hours apart from Dilantin for better absorption."</p> <p>The review of the current physician's orders dated January 2010 revealed the following orders:</p> <p>Calcium w/Vit. D 600 mg-400 tablet, 1 tab by mouth twice daily with meals to prevent bone loss</p> <p>Dilantin Chewable 50 mg (2 tabs), 100 mg BID .</p> <p>During interview with the RN on January 15, 2010 at 1:37 p.m., it was acknowledged that Client #3 had written instructions on the MAR to have the Calcium and the Dilantin given at least 2 hours apart for better absorption.</p> <p>At the time of the survey, there was no evidence the facility had ensured the Calcium was</p>	W 369	<p>W 369. 1.</p> <p>a. The facility's RN will retrain TME on Medication Administration in accordance with the Physician's Order Form.</p>	03/20/10

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W 369	<p>Continued From page 13</p> <p>administered with the dinner meal in accordance with the physician's order.</p> <p>2. The facility failed to ensure each of Client #1's medications were administered as prescribed as evidenced below:</p> <p>On January 13, 2010 at 6:27 p.m., Client #1 was observed to have finished eating his dinner meal. On January 13, 2010, at 7:23 p.m. Client #1 was administered his evening medication by the Trained Medication Employee (TME). The client was observed to receive Calcium w/Vit. D 600 mg-400 tablet, 1 tab. The client was observed to receive this medication TME indicated that the client was prescribed Calcium to prevent bone loss.</p> <p>The review of the current physician's orders dated January 2010 on January 14, 2010 at 9:58 a.m. confirmed that "Calcium w/Vit. D 600 mg-400 tablet, 1 tab by mouth twice daily with meals to prevent bone loss" was prescribed.</p> <p>Interview with the RN on January 15, 2010 at 1:37 p.m., acknowledged the primary care physician prescribed the calcium to be administered with meals.</p> <p>At the time of the survey, there was no evidence that nursing services had ensured that the Calcium was administered at mealtime as prescribed.</p>	W 369	<p>W 369. 2.</p> <p>The facility RN will retrain TME on Medication Administration in accordance with the Physician's Order Form.</p>	03/20/10	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012		
(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
1000	INITIAL COMMENTS TORBIT, MARCELLA A licensure survey was conducted from January 13, 2010 through January 15, 2010. A random sampling of two residents was selected from a resident population of four males with various disabilities. The findings of the survey were based on observations in the home and one day programs, interviews with staff in the home and at the day programs, as well as a review of the clinical, administrative, and habilitation records; including a review of the unusual incident/investigation reports.	1000		
1074	3503.3(c) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (c) Drawer space; and... This Statute is not met as evidenced by: Based on observation, and interview, the GHMRP failed to ensure that the bedroom was equipped with drawer space for one of the four residents in the facility (Resident #2). The finding includes: The GHMRP failed to ensure that Resident #2 had his own drawer space for storing clothing, as evidenced below: On January 15, 2010, at approximately 2:45 p.m., inspection of the bedroom shared by Residents #3 and #4, revealed that Resident #2's had no drawer storage for his clothing. The surveyor	1074	I 074 (c). The facility will provide drawer storage for Client #2 by 03/31/10 at which time, the QMRP and House manager will ensure Client #2 underwear and socks are appropriately stored in his <u>drawers.</u>	03/31/10

Health Regulation Administration

I. J. Thomas
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

President

(X6) DATE

3-1-10

STATE FORM

MY0011

If continuation sheet 1 of 17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 6827 1ST STREET, NW WASHINGTON, DC 20012		
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1074	Continued From page 1 was directed the resident's closet where his underwear and socks were observed stored in a gym bag. Slacks were observed neatly folded and placed on the shelf of the closet. Interview the Residential Director (RD) during the environmental observations on January 15, 2010, revealed that Resident #2 destroyed his dresser during a behavioral episode in early 2009 and since that time, his clothing had been stored in his closet. Further interview with the Qualified Mental Retardation Professional (QMHP) and the RD revealed that the resident had not exhibited any recent episodes of property destruction. Record review on January 15, 2010, at 1:07 p.m. had revealed that the Resident #2's had no recent behavioral episodes documented. At the time of the survey, there was no evidence the QMHP had ensured that the bedroom of Resident #2 was equipped with the minimum required items (drawer space) as required by District of Columbia Municipal Regulations.	1074		
1075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the QMHP failed to provide a night stand for each resident for two of the four residents residing in the facility. (Residents #2 and #3) The findings includes:	1075		

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I 075	Continued From page 2 On January 15, 2010, at approximately 2:45 p.m., observation in the bedroom of shared by Residents #2, #3, and #4 revealed that there was no nightstand available for Residents #2 and #3. Interview with the RD on January 15, 2010, during the environmental observations revealed that Resident #2 had broken his and Resident #3's nightstands during a behavioral episode and that they had not been replaced. Further interview with the Qualified Mental Retardation Professional (QMRP) and the RD revealed that the resident had not exhibited any recent episodes of property destruction. Record review on January 15, 2010, at 1:07 p.m. had revealed that the Resident #2's had no recent behavioral episodes documented. At the time of the survey, they was no evidence the GHMRP had ensured that the bedroom of Residents #2 and #3 was equipped with the minimum required items (nightstands) as required by District of Columbia Municipal Regulations.	I 075	I 075 (d). The facility will provide night stand for each of Clients #2 and #3 by 03/31/10.	03/31/10
I 090	3504.1 HOUSEKEEPING 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. This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to ensure the environment was maintained for four of the four residents (Residents #1, #2, #3, and #4) as evidenced by the concerns identified in this section.	I 090		

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 6327 1ST STREET, NW WASHINGTON, DC 20012		
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1 090	<p>Continued From page 4</p> <p>2:35 p.m., she immediately telephoned the administrator to inform her of the situation. Upon inspection of the dryer, the duct and vent system, and maintenance staff was observed to remove the aforementioned lint. Interview with the maintenance supervisor indicated that he had been instructed by management to purchase a new lint filter, and if it was not available, to purchase a new dryer. On January 15, 2010, at 4:20 p.m., further observation of the laundry area in the basement revealed a new dryer and duct system had been installed. Inspection of the dryer vent revealed it had been cleaned and attached to a newly installed duct. Inspection of the dryer revealed it was attached to the duct and when turned on, it appeared to operate properly.</p> <p>Interview with the residential manager on January 15, 2010, at 4:47 p.m. revealed that an internal environmental inspection of the group home was to be conducted on a regular basis. Review of the facility's policy on "Repairs and Maintenance," section 3b revealed, "Preventive maintenance will be conducted daily, weekly, monthly, quarterly, semi-annually or annually in an effort to maintain facility and environmental safety." At the time of the survey, there was no evidence the policy on repairs and maintenance had been effectively implemented, as required to prevent the aforementioned heavy accumulation of lint.</p> <p>2. Inadequate lighting was observed in the bedroom of Residents #2, #3, and #4. Interview with the residential director, revealed that the light required a special bulb, which would require replacement by maintenance. During this time a lamp was observed on top of Resident #4's wardrobe. Interview with the RD revealed it was not connected to an electrical source, because the cord was too short to reach the outlet.</p>	1 090	<p>I 090. 2</p> <p>The light bulb in the bedroom of Residents #2, #3, and #4 has been replaced.</p> <p>Lamp observed on top of Resident #4's wardrobe has been moved and situated on Resident #4's nightstand close to an electrical source and has been connected to the electrical source.</p>	01/18/10

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 8627 1ST STREET, NW WASHINGTON, DC 20012		
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I 090	Continued From page 5 3. A large amount of scaling paint was observed on the exterior walls of the facility. 4. At the rear exit from the second floor, a crack was observed across the width of the walkway. 5. Curtains hanging from the window, located between the exit door and Resident #4's closet, were several inches longer the height of the window. This caused the curtains to hang loosely on the floor, creating a potential trip hazard. 6. Five of the six trash cans in the back yard were observed to have holes in the bottom and/or lids. Interview with the residential manager revealed the damage was probably caused by squirrels. 7. A large hole was observed in the ceiling, beside the light fixture in the bathroom, which was located in the basement of the facility. 8. The window located approximately four feet from Resident #3's bed, was observed to have an large area of paint scaled on the sill, which caused the natural wood to be visible. The size of the unpainted area was approximately 12 inches by 1 inch. 9. The cover for the light fixture located near the front of Resident #1's bedroom was missing. 10. The wood railing beside the steps, leading from the deck to the back yard, was observed to have numerous cracks. 11. A section of the protective front panel of the furnace was missing. 12. The bed rail on the front of Resident #1's bed	I 090	I 090. 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12. All observations will be completely taking care of by 03/31/10.	03/31/10

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I 090	Continued From page 6 was difficult to secure in an "up position". The RN indicated that staff had reported this concern earlier during the day on January 15, 2010.	I 090		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record, the group home for mentally retarded person's (GHMRP) failed to obtain an annual health screening as required by this section for two consultants.</p> <p>The finding includes:</p> <p>On January 14, 2010, at 9:30 a.m., the qualified mental retardation professional (QMRP) was requested to obtain the files of the GHMRP staff and consultants for review.</p> <p>The review of the records on January 15, 2010, at 1:17 p.m. revealed that current health screening documents were not available for the following individuals:</p> <p>a. Occupational therapist: Expired on October 23, 2009.</p> <p>b. Pharmacist: A document entitled "Tuberculosis Symptom Surveillance for Positive PPD's" dated July 12, 2009 was provided. The</p>	I 206	<p>I 206</p> <p>a. The Occupational Therapist is no longer providing services for Wholistic Services, Inc.</p> <p>b. Wholistic Services will obtain current health screening documents from the Pharmacist. Wholistic Services Inc. will ensure all health screening documents for consultants are obtained in a timely manner to ensure compliance with personnel policy.</p>	03/15/10

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I 229	<p>Continued From page 8</p> <p>device with voice output allows him to scan pictures horizontally, vertically and diagonally depress a cell which correlates pictures with basic fundamental wants and needs during communicative acts. Review of the client's skill acquisition program revealed the client and the staff will use manual signs to express basic wants and needs such as eat, more, water, bathroom, yes and no.</p> <p>Interview with the direct care staff on January 15, 2010, at 4:35 p.m. revealed the communication device is used after dinner. Further interview, however, revealed the staff did not know how to sign eat, more, water and bathroom.</p> <p>Review of the training records on January 15, 2010, at 10:30 a.m., revealed that staff was trained on Client #2's communication program on October 14, 2009. There was no evidence, however, that each staff had been trained on sign language to facilitate more effective communication with the client.</p>	I 229	<p>I 229. (f) All Staff persons have been trained on sexuality by the Social Worker.</p> <p>The facility's QMRP has retrained staff on the effective use of Client #2's communication device and use of manual signs (eat, drink, more, water, finish, bathroom yes and no) to facilitate more effective communication with Client #2.</p> <p>QMRP will ensure that the staff training is done on a regular basis to improve staff communication with Client #2.</p>	01/21/10 01/21/10
I 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that professional services were provided in accordance with the needs of two of the four residents of the GHMRP. (Residents #1 and #3)</p>	I 401		

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I 206	Continued From page 7 review of this document, however, provided no evidence that an annual health inventory had been performed, which allowed the consultant to perform the required duties. Interview with the QMRP prior to the exit on January 15, 2010, at 4:45 p.m. confirmed that the aforementioned health certifications were not available for review at the GHMRP.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on record review and interview, the GHMRP fail to train staff in specialty area of communication. The finding includes: Review of the training records on January 15, 2010, at 10:30 a.m., revealed the GHMRP failed to provide training on sexuality for all staff at the time of the survey. Review of Client #2's speech evaluation dated June 21, 2009, on January 14, 2010, at approximately 5:00 p.m., revealed Client #2 participates in a communication program to utilize a low tech communication device to facilitate his communication with persons in the environment. Further review revealed his communication	I 229		

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I 401	Continued From page 9 The finding includes: I. The GHMRP failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated and monitored services for Resident #1). A. The GHMRP's QMRP failed to coordinate services with the interdisciplinary team (IDT) to determine how Resident #1's safety needs were to be addressed when he addressed when he was in bed as evidenced below: On January 14, 2010, at 11:25 a.m., the review of an unusual incident report dated January 15, 2009 at 12:02 a.m., staff reported that Resident #1 was getting down off his bed and fell on the floor. The incident report further revealed that "staff tried to help [Resident #1] but he was already on the floor. He sustained an abrasion on his head above his left eye, above the eyebrow." Interview with the QMRP on January 15, 2010, at 12:08 p.m. revealed staff informed him they had just checked on Resident #1, before turning their attention to his room mate. The staff reported to the QMRP that Resident #1 appeared to be asleep when he was checked, however moments later, he was observed on the floor. On January 15, 2010, at 12:20 p.m., the review of the written statements completed by the staff in the room with the resident when he fell, revealed that Resident #1's "fall was the result of [the resident] attempting to get out of his bed and losing his balance. The investigation report for the incident concluded that "[the resident] has an unsteady gait which has resulted in the need for one on one assistance during waking	I 401	I 401. I A. QMRP will ensure that 1 of 2 night staff is assigned to Client #1's bedroom to regularly check on him while in bed sleeping for added safety.	

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 65		STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012		
(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 401	Continued From page 10 hours....Recommendations: None." Interview with the registered nurse (RN) on January 15, 2010, at 12:10 p.m. revealed resident safety concerns are reviewed by the Human Rights Committee (HRC). The HRC minutes dated February 11, 2009, revealed Resident #1 requires one on one staffing in his group home. "Recommendation of the team: Continue to monitor, continue one-on-one". The HRC minutes also included recommendations to (1) continue the use of a hospital bed with rails for safety and (2) continued to wear the prescribed helmet helmet for protection. Additional interview with the RN on January 15, 2010, at 1:30 p.m. revealed that at the time of the HRC (February 11, 2009) recommendation, Resident #1 already had a hospital bed with rails. The medical/habilitation records, however, failed to provide specific instructions on how the hospital bed was to be used for the resident. Record review also failed to reveal a current physician's order for Resident #1 have a hospital bed. (Note: On January 15, 2010 at 2:30 p.m., one of the pins required to secure the bed rail in an upright position was difficult to engage.) At the time of the survey, there was no evidence the QMRP had coordinated with the IDT to determine how the hospital bed with rails was to be used for Resident #1. II. The QMRP failed to coordinate with the IDT team to clearly identify Resident #1's level of required supervision as evidenced below: a. On January 15, 2010, at 12:45 p.m., review of the psychological assessment (dated February 4, 2009, recommended one on one supervision to	I 401	I 401. I The Physical Therapist will do an assessment with client #1 in bed to determine whether to continue the use of hospital bed with rails or not. Findings will be presented to the IDT and HRC.	03/31/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 8627 1ST STREET, NW WASHINGTON, DC 20012		
(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 401	Continued From page 12 that the QMRP had coordinated with the IDT to determine when, and if, the one on one supervision which was approved and recommended by the HRC on February 11, 2009 would be implemented. III. The GHMRP failed to assure that all drugs are administered in compliance with the physician's orders Residents # 1 and #3. A. The GHMRP failed to ensure each medication was administered within the time frames assigned on the MAR for Resident #3 as evidenced below. On January 13, 2010, at 6:20 p.m., Resident #3 was observed to have finished eating his dinner meal. On January 13, 2010, at 7:14 PM, Resident #3 was administered his evening medication by the Trained Medication Employee (TME). The review of the medications cards from which the medications were punched revealed orders for the following: (1) Dilantin Chewable 50 mg (2 tabs), 1m BID (7 a.m. and 7 p.m.) (2) Calcium w/Vit.D 600 mg-400 tablet, 1 tab twice daily with meals to prevent bone loss. (9 a.m. and 5 p.m.) During the medication administration, the TME revealed that the Dilantin was prescribed for seizures and that the Calcium was prescribed to prevent bone loss. Review of the January 2010 MAR on January 13, 2009, after the medication administration revealed a handwritten note by the nurse which stated ".....Remember calcium should be	I 401	I 401. III A. The facility RN will retrain TME on medication administration in accordance with the Physician's Order Form.	03/20/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 8627 1ST STREET, NW WASHINGTON, DC 20012		
(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 401	<p>Continued From page 13</p> <p>administered at least two hours apart from Dilantin for better absorption."</p> <p>The review of the current physician's orders dated January 2010 revealed the following orders:</p> <p>(1) Calcium w/Vit. D 600 mg-400 tablet, 1 tab by mouth twice daily with meals to prevent bone loss</p> <p>(2) Dilantin Chewable 50 mg (2 tabs), 100 mg BID."</p> <p>During interview with the RN on January 15, 2010, at 1:37 p.m., it was acknowledged that Resident #1 had written instructions the MAR to have the Calcium and the Dilantin given at least 2 hours apart for better absorption.</p> <p>At the time of the survey, there was no evidence the GHMRP had ensured coordination between the nurse and the TME to ensure that the Calcium was administered with the dinner meal in accordance with the physician's order. Additionally, at the time of the survey there was no evidence the GHMRP had ensured coordination between the nurse and the TME to ensure the nursing instructions that two hours elapse after administration of the calcium, before the administration of the Dilantin.</p> <p>B. The GHMRP failed to ensure each medication was administered for Resident #1 within the time frames assigned on the medication administration record (MAR) as evidenced below:</p> <p>On January 13, 2010, at 6:27 p.m., Resident #1 was observed to have finished eating his dinner meal. On January 13, 2010, at 7:23 p.m., Resident #1 was administered his evening</p>	I 401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012		
(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 401	Continued From page 15 order. Additionally, the review of the available records during the survey revealed that a past order the the resident to use a hospital bed was not available. Observation of the Resident #1's bed on January 15, 2010, at 2:30 p.m. revealed one of the pins required to secure the bed rail in an upright position was difficult to engage. The RN indicated that staff had notified her earlier that day of the concern identified with the bed rails. The nurse indicated that a immediate request would be made to have the bed repaired. At the time of the survey, there was on evidence that the IDT had concurred on how and when the bedrails were to be used for the resident.	I 401	I 401. III IV. The Physical Therapist will do an assessment with client #1 in bed to determine whether to continue the use of hospital bed or not. Findings will be presented to the IDT and HR.	03/31/10
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide continuous active treatment for one of two clients in the sample. (Client #2) The finding includes: Observation on January 14, 2010, at 4:03 p.m. revealed the facility's direct care staff instructing Client #2 to go to the bathroom. At 4:12 p.m., the direct care staff pointed to the bathroom and told Client #2 to wash his hands. The client walked into the bathroom and walked right out. The direct	I 420		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2010
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012		
(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 420	Continued From page 16 care staff pointed to the bathroom and stated, "Go wash your hands". At 4:15 p.m., the house manager told Client #2 to go into the kitchen to help prepare snacks. During this time, the client was not observed to use a communication device. Review of Client #2's speech evaluation dated June 21, 2009, on January 14, 2010, at approximately 5:00 p.m., revealed Client #2 participates in a communication program to utilize a low tech communication device to facilitate his communication with persons in the environment. Further review revealed his communication device with voice output allows him to scan pictures horizontally, vertically and diagonally depress a cell which correlates pictures with basic fundamental wants and needs during communicative acts. Review of the client's acquisition program revealed the client and the staff will use manual signs to express basic wants and needs such as eat, more, water, bathroom, yes and no. Interview with the direct care staff on January 15, 2010, at 4:35 p.m. revealed the communication device is used after dinner. Further interview revealed the staff did not know how to sign eat, more, water and bathroom. Review of the training records on January 15, 2010, at 10:30 a.m., revealed that staff was trained on Client #2's communication program on October 14, 2009. There was no evidence that training was effective.	I 420	I 420 The facility's QMRP has retrained staff on the effective use of Client #2's communication device and use of manual signs (eat, drink, more, water, finish, bathroom yes and no) to facilitate more effective communication with Client #2. QMRP will ensure that staff is trained on a regular basis to improve staff communication with Client #2.	01/21/10