

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/29/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 06	STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011
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(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
1 000	<p>INITIAL COMMENTS</p> <p>On February 19, 2008 at approximately 10:10 AM this office received a complaint via telephone from the United Cerebral Palsy of Washington and Northern Virginia Adult Services Day Treatment Facility (UCP). The complainant reported that Resident #1 alleged that he was touched on his buttocks continuously by a peer during the night of February 17, 2008. At 11:53 AM, UCP forwarded an unusual incident report (URI) summarizing the allegation.</p> <p>An onsite visit was initiated on February 27, 2008. The findings of the investigation were based on observations at the group home and the day program, interviews with staff at the group home and the day program, as well as a review of records from October 1, 2007 through February 28, 2008. The findings of the investigation revealed that Resident #1's allegation of being inappropriately touched by a peer at his group home was unsubstantiated. During the investigation, however standard level deficiencies were identified.</p>	1 000		
1 206	<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 interviews and record review, the facility failed to achieve compliance with State</p>	1 206		

Health Regulation Administration

Michelle Johnson

VP and Clinical Director

4/4/08
(X6) DATE

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

STATE FORM

6899

3KWM11

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I 206	Continued From page 1 regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6) for one staff. The finding includes: Interview with Direct Care Staff #1 on February 28, 2008 revealed that he had been working at the facility for several weeks. Interview with the Qualified Mental Retardation Professional (QMRP) indicated that the administrative office would provide the files on February 29, 2008. Interview with the Residential Manager on February 29, 2008 revealed she was informed by the administrative office that the health certificate was not available for Direct Care Staff #1. Record review revealed a job description for Direct Care Staff #1 which was dated February 7, 2008. There was no evidence the GHMRP ensured each staff had a current health certificate prior to beginning to work in the group home.	I 206	I 206 Staff #1 has completed an annual physical (please find herewith). In the future, the facility shall adhere to the policy of staff providing most current annual physical prior to employment.	04/09/08	
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 observation, interview and record, the facility failed to ensure continuous training was provided to each employee to enable them to effectively and competently implement Resident #1's behavior support plan (BSP). The finding includes:	I 229			

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I 229	<p>Continued From page 2</p> <p>On February 28, 2008 at 3:40 PM a direct care staff requested Resident #1 to go to the bathroom located inside his bedroom to wash his hands. While in the bathroom the resident stated "Who's been using my bathroom? He then stated "Tell him to stop using my bathroom." When questioned who he was talking about the resident responded that it was Resident #2. "Tell him (Resident #2) to stop using my bathroom at night." At 3:50 PM Resident #1 stated, "Tell him not to use my bathroom and stay out of my room at night. He messed it up." On February 29, 2008 at 9:30 AM, Resident #1 started talking about his bathroom again. "He messed it up (Resident #2). He P...(urinated) on the floor in private."</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the resident had a BSP which addressed making false allegation. Further interview QMRP revealed he often made false allegations. The QMRP stated that staff had been trained on the implementation documentation of the BSP.</p> <p>The review of the BSP dated October 7, 2007 revealed the resident had a goal to "Reduce making false allegations to zero time per month for twelve consecutive months". The BSP interventions strategies indicated "Address false allegation when it occurs by asking the resident if he is certain the allegation is true." The review of the functional assessment in the BSP revealed "Staff should document all allegations, regardless of staff's opinion about their truthfulness.</p> <p>The review of ABC data at the group home indicated the client made a false allegation on February 5, 2008. The review of ABC data from</p>	I 229	<div style="border: 1px solid black; padding: 5px;"> <p>I 229 Staff have been re-trained on Resident' #1's Behavior Support Plan (BSP), and accurate collection of data. During the training, emphasis was laid on accurate and consistent documentation of behaviors, in particular, false allegations. The QMRP will, on a weekly basis review Resident #1's behavior data sheets to ensure compliance.</p> </div>	04/09/08
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I 229	Continued From page 3 October 24, 2007 through February 4, 2008 revealed no false allegations at the group home. The review of data documented on "Monthly Psychiatric Visit and Psychotropic Medication Reviews" revealed no false allegations from October 2007 through January 2008. Additionally one incident was documented in February 5, 2008. There was no evidence staff was effectively trained on the implementation of Resident #1's BSP.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interviews and the review of the GHMRP's unusual incident reports, the GHMRP failed to report an allegation of abuse in accordance with federal and state regulations. The finding includes: On February 19, 2008 at approximately 10:10 AM this office received a complaint via telephone from the United Cerebral Palsy of Washington and Northern Virginia Adult Services Day Treatment Facility (UCP). The complainant reported that Resident #1 alleged that he was	I 379		

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I 379	<p>Continued From page 4</p> <p>touched on his buttocks continuously by a peer during the night of February 17, 2008. At 11:53 AM, UCP forwarded an unusual incident report (URI) summarizing the allegation.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) at the group home 2:02 PM on February 28, 2008 revealed the day program reported the resident's allegation of being inappropriately touched at his group home to him by telephone at the end of the day on February 18, 2008. The QMRP indicated no unusual incident report was completed by the group home because the resident made the allegation at the day program. Record review revealed no documented evidence that Resident #1's allegation of being inappropriately touched by a peer at his group home was reported to DOH by the group home.</p>	I 379	<div style="border: 1px solid black; padding: 5px;"> <p>I 379 In the future, the GHMRP shall inform the Department of Health (DOH) of incidents irrespective of the location. Staff have been trained on incident reporting. Training will be done semi-annually.</p> </div>	04/09/08
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation training to Resident #1 in accordance with the Individual Habilitation Plan.</p> <p>The finding includes:</p> <p>1. On February 28, 2008 at 3:40 PM a direct care staff requested Resident #1 to go to the bathroom located inside his bedroom to wash his hands. While in the bathroom the resident stated "Who's been using my bathroom?" He then stated "Tell him to stop using my bathroom." When</p>	I 422		

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I 422	<p>Continued From page 5</p> <p>questioned who he was talking about the resident responded that it was Resident #2. "Tell him (Resident #2) to stop using my bathroom at night." At 3:50 PM Resident #1 stated, "Tell him not to use my bathroom and stay out of my room at night. He messed it up." On February 29, 2008 at 9:30 AM, Resident #1 started talking about his bathroom again. "He messed it up (Resident #2). He P...(urinated) on the floor in private."</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on February 28, 2008 indicated that the staff was provided training on June 7, 2007 concerning the use of Resident #1's bathroom. Instructions indicated "No customer other that Resident #1 should use the bathroom on the first floor. Staff should direct all other residents to use the second floor bathroom." Interview with the QMRP and the Residential Manager revealed the resident was questioned concerning the validity of his statements about the use of his bathroom and it could not be verified that it was used by Resident #2.</p> <p>The review of the BSP dated October 7, 2007 revealed the resident had a goal to "Reduce making false allegations to zero time per month for twelve consecutive months". The BSP interventions strategies indicated "Address false allegation when it occurs by asking the resident if he is certain the allegation is true. The review of the functional assessment in the BSP revealed "Staff should document all allegations, regardless of staff's opinion about their truthfulness. The review of the ABC form revealed no evidence the allegations made by the resident on the aforementioned dates were documented to reflect implementation of the BSP as written.</p>	I 422		

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I 422	<p>Continued From page 6</p> <p>2. Interview with the Qualified Mental Retardation Professional (QMRP) and direct care staff on February 28 and February 29, 2008 indicated that Resident #1 often made false allegations (untrue statements) about others and situations. Further interview with the QMRP indicated when questioning determined that his statements were false, the Behavior Support Plan (BSP) did not require the allegation to be documented. According to the BSP dated October 1, 2007, staff should ask the resident if he is certain the allegation is true. If he said the allegation was not true, staff should thank him for being truthful. Nothing else should be said about the incident.</p> <p>The review of the functional assessment in the BSP however revealed "Staff should document all allegations, regardless of staff's opinion about their truthfulness....Allegations will continue to be treated seriously and investigated." There was no evidence the group home documented all allegations, as required by the resident's BSP.</p> <p>The review of ABC data from October 24, 2007 through February 4, 2008 revealed no false allegations at the group home. The review of data documented on "Monthly Psychiatric Visit and Psychotropic Medication Reviews" revealed no false allegations from October 2007 through December 2008.</p> <p>A memorandum dated February 12, 2008 on analysis of raw data at the day treatment program revealed the resident made 43 false allegations during the month of January 2008. Data collection revealed the resident made an average of 2.2 false allegations each day at his day treatment program. Interview with the case manager at the day treatment program on February 28, 2008 revealed the resident had a</p>	I 422	<div style="border: 1px solid black; padding: 10px;"> <p>I 422, 1 Cross reference I 229</p> <hr/> <p>I 422, 2 Staff have been re-trained on Resident #1's Behavior Support Plan (BSP) and accurate collection of data. During the training, emphasis was laid on accurate and consistent documentation of behaviors, in particular, false allegations. The QMRP will, on a weekly basis review Resident #1's behavior data sheets to ensure compliance.</p> <p>The facility shall on a monthly basis present behavior data sheets from the residential facility and the day program to Wholistic's psychotropic medication review team for discussion.</p> </div>	04/09/08
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I 422	Continued From page 7 large number of false allegation because all false allegations were documented. Further interview with the case manager indicated that the resident continued to regularly make false allegations. There was no evidence that the frequency of the false allegations at the day program which was reported to the group home was provided to the interdisciplinary team for follow-up. [See also Federal deficiency report - W159]	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on on observation, interview and record review, the GHMRP failed to ensure that the rights of each resident were protected. The findings include: See Federal Deficiency Report - Citation W104, W149, W153, W154, W249, and W331.	I 500	I 500 See responses to W104, W149, W153, W154, W249, and W 331	04/09/08

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W 000 INITIAL COMMENTS

On February 19, 2008 at approximately 10:10 AM this office received a complaint via telephone from the United Cerebral Palsy of Washington and Northern Virginia Adult Services Day Treatment Facility (UCP). The complainant reported that Client #1 alleged that he was touched on his buttocks continuously by a peer during the night of February 17, 2008. At 11:53 AM, UCP forwarded an unusual incident report (URI) summarizing the allegation.

W 000

An onsite visit was initiated on February 27, 2008. The findings of the investigation were based on observations at the group home and the day program, interviews with staff at the group home and the day program, as well as a review of records from October 1, 2007 through February 28, 2008. The findings of the investigation revealed that Client #1's allegation of being inappropriately touched by a peer at his group home was unsubstantiated. During the investigation, however standard level deficiencies were identified.

W 104

W 104 483.410(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, interviews with staff, and the review of records, the facility's governing body failed to provide general operating directions over the facility in the following areas:

1. The governing body failed to implement its established procedure on incident handling and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M.atha Shoro</i>	TITLE <i>VP and Clinical Director</i>	(X6) DATE <i>4/14/08</i>
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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 104 Continued From page 1 reporting for Client #1. [See W149]

2. The governing body failed to ensure that outside agencies were informed of Client #1's unusual incident in accordance with District law 22 District of Columbia Municipal Regulations (DCMR), Chapter 35, Section 3519.10. [See W153]

3. The governing body failed to ensure Client #1's allegation of abuse was thoroughly investigated. [See W154]

W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its established procedure on incident handling and reporting for Client #1.

The finding includes:

At 11:53 AM on February 19, 2008, the Health Regulation Administration received an unusual incident report (dated February 18, 2008) via facsimile from the day treatment facility describing Client #1's allegation of being inappropriately touched by a peer at his group home. Interview with the Qualified Mental Retardation Professional on February 27, 2008 revealed that the facility did not generate an unusual incident report (UIR) because the allegation was made by the client at his day program.

W 104

W 149

W 149

This is a misquotation of the QMRP's words. The QMRP informed the DOH surveyor that an incident report was not generated by the home because the day program had informed the QMRP that DOH had been informed via telephone and an incident report faxed. This was evident on the incident report sent to the home by the day program.

At no point in time during the survey process did the QMRP tell the surveyor that "an incident report was not generated by the group home because the investigation of the alleged incident could not substantiate that Client #1 was inappropriately touch by a peer at his group home." This is a misstatement.

W149
Cross Reference I 229.

04/09/08

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W 149	Continued From page 2 The QMRP also indicated that an incident report was not generated by the group home because the its investigation of the alleged incident could not substantiate that the Client #1 was inappropriately touched by a peer at his group home. This procedure was further corroborated by the incident management coordinator during an interview on March 7, 2008. The review of the facility's procedures on "Incident handling and Reporting Procedures..." revealed reportable or serious reportable incidents would be reported to the Department of Health (DOH). Although DOH was notified of the allegation of abuse by Client #1's day treatment program, there was no evidence the allegation was reported to DOH by the group home as specified in the agency "Incident and Reporting Procedures..." [See also W153]	W 149			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interviews and the review of the facilities unusual incident reports, the facility failed to report an allegation of abuse in to the Department of Health in accordance with federal and state regulations through established procedures for Client #1.	W 153			

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W 153	Continued From page 3 The finding includes: At 11:53 AM on February 19, 2008, the Health Regulation Administration received an unusual incident report via facsimile from a day treatment facility describing Client #1's allegation of being touched inappropriately by a peer at his group home. The incident report documented that on February 18, 2008 at approximately 2:30 PM, the client reported to two support associates and the Support Services Coordinator that he had been touched inappropriately by a client at the group home. Interview with the Support Services Coordinator on February 27, 2008 revealed that when she asked the client what was wrong, he responded to her that an individual at his home came into his bedroom and touched him on his buttocks, then pointed to them. The client reported to the Support Services Coordinator that the peer continued to feel on and touch him. The client then reportedly stated to the other client "I'm not a woman." Interview with the Qualified Mental Retardation Professional (QMRP) at the group home 2:02 PM on February 28, 2008 revealed the day program reported the client's allegation to him by telephone on February 18, 2008. The QMRP indicated no unusual incident report was generated by the group home because the client made the allegation at the day program. [See also W149,1]	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154	W 153 In the future, the GHMRP shall inform the Department of Health (DOH) of incidents irrespective of the location. Staff have been trained on incident reporting. Training will be done semi-annually.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/29/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 06	STREET ADDRESS, CITY, STATE, ZIP CODE 7129 7TH STREET, NW WASHINGTON, DC 20011
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W 154	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that an allegations of abuse reported by Client #1 was thoroughly investigated.</p> <p>The findings include:</p> <p>[Cross Refer to W153] Although the Client's behavior data at the day program revealed 43 false allegations in January 2008, the day program indicated that the client had never made an allegation of sexual abuse prior to the February 18, 2008 incident. Interview with the day program staff and the review of the day program investigative report revealed the client's consistent recall of the incident and his continued insistence that the inappropriate touching occurred, suggested that the allegation required further investigation.</p> <p>The investigation was initiated by the surveyor at Client 1's day treatment program on February 27, 2008 at 2:45 PM. The surveyor interviewed the two direct support professionals to whom Client #1 made the allegation on February 18, 2008, and also the Support Services Coordinator to whom the allegation was reported. The Licensed Practical Nurse (LPN) who conducted a physical assessment of the client on February 19, 2008 at 9:30 AM was also interviewed.</p> <p>The day treatment program investigated the allegation immediately on February 18, 2008 and concluded on February 26, 2008. Although the day treatment program's investigative findings were inconclusive, it recommended that the</p>	W 154	<div data-bbox="941 1029 1347 1491" style="border: 1px solid black; padding: 5px;"> <p>W 154 The Governing body of Wholistic has advised the Incident Management Coordinator to ensure that investigative procedures are thoroughly adhered to. Incident reporting and investigation procedures shall be reviewed monthly by Wholistic's Incident Management Team.</p> </div>	04/09/08
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W 154 Continued From page 5
client's allegation of inappropriate touching be thoroughly investigated by the group home, Incident Management Enforcement Unit (IMEU) and other appropriate authorities.

W 154

The review of the group home's internal investigative report which was completed on February 24, 2008, revealed that except for the residential manager, there was no evidence that direct care staff working the 12:00 AM to 8:00 AM shift and the 8:00 AM to 4:00 PM shift were interviewed/questioned about the allegation.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

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, interview and record verification, the facility failed to ensure Client #1's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for Client #1.

The findings include:

1. The QMRP failed to ensure continuing training was provided to each employee to enable them to effectively and competently implement Client #1's behavior support plan (BSP). [See W189]
2. The QMRP failed to ensure Client #1 received continuous active treatment to address his targeted behavior of making false allegations. [See W249]

W 159, 1, 2, 3
Staff have been re-trained on Resident' #1's Behavior Support Plan (BSP) and accurate collection of data. During the training, emphasis was laid on accurate and consistent documentation of behaviors, in particular, false allegations. The QMRP will, on a weekly basis review Resident #1's behavior data sheets to ensure compliance.

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W 159	Continued From page 6 3. The QMRP failed to coordinate the documentation of Client #1's targeted behavior, false allegations at the group home and with the day treatment program to ensure accuracy in reporting of the behavioral frequency to the interdisciplinary team. [See W252] 4. Interview with the QMRP on February 28, 2008 at 2:02 PM revealed that Client #1 became very aggressive if anyone came into his room. He did not want to be touched by his peers, even on the wrist and sometimes said, "I'm not a woman. " if anyone touched him. The QMRP indicated that the client began saying that about four months ago. There was evidence that this new behavior had been investigated to determine its origin or if and how it should be addressed.	W 159	W 159, 4 In the future, the QMRP shall report such incident to the Incident Management Coordinator for further investigation.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuous training was provided to each employee to enable them to effectively and competently implement Client #1's behavior support plan (BSP). The finding includes: On February 28, 2008 at 3:40 PM a direct care staff asked Client #1 to go to the bathroom located inside his bedroom to wash his hands. While in the bathroom, the client stated "Who's	W 189		04/09/08

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W 189	<p>Continued From page 7</p> <p>been using my bathroom?" He then stated "Tell him to stop using my bathroom." When questioned who he was talking about the client responded that it was Client #2. "Tell him (Client #2) to stop using my bathroom at night." At 3:50 PM Client #1 stated, "Tell him not to use my bathroom and stay out of my room at night. He messed it up!" On February 29, 2008 at 9:30 AM, Client #1 started talking about his bathroom again. "He messed it up (Client #2). He P... (urinated) on the floor in private."</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the client had a BSP which addressed making false allegations. Further interview with the QMRP and also with the group home staff revealed he often made false allegations. The QMRP stated that staff had been trained on the implementation and documentation of the BSP.</p> <p>The review of the BSP dated October 7, 2007 revealed the client had a goal to "Reduce making false allegations to zero times per month for twelve consecutive months". The BSP interventions strategies indicated "Address false allegation when it occurs by asking the client if he is certain the allegation is true." The review of the functional assessment in the BSP revealed "Staff should document all allegations, regardless of staff's opinion about their truthfulness." The review of the ABC form revealed no evidence the allegations made by the client on the aforementioned dates were documented to reflect implementation of the BSP for making false allegations. Further of the behavioral data revealed no false allegations between October 24, 2007 and February 4, 2008 at the group home. One incident was documented on</p>	W 189	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> <p>W 189 Cross Reference W159</p> </div>	04/09/08
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W 189	Continued From page 8 February 5, 2008. There was no evidence staff was effectively trained on the implementation of Client #1's BSP. [See also W252]	W 189			
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 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 as soon as the interdisciplinary team formulated the individual program plan (IPP), Client #1 received a continuous active treatment plan consisting of needed interventions to achieve identified objectives. The finding includes: The review of the BSP dated October 7, 2007 revealed the client had a goal to "Reduce making false allegations to zero times per month for twelve consecutive months". The BSP interventions strategies indicated "Address false allegation when it occurs by asking the client if he is certain the allegation is true." The review of the functional assessment in the BSP revealed "Staff should document all allegations, regardless of staff's opinion about their truthfulness. Observation of the client's exhibited allegations during the survey revealed no evidence that staff	W 249	W 249 Cross Reference W159	04/09/08	

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W 249	Continued From page 9 implemented the BSP for monitoring false allegations as recommended by the psychologist. [See also W189]	W 249		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure data relative to the accomplishment of the behavioral program objective was documented in measurable terms for Client #1.</p> <p>The finding includes:</p> <p>1. The review of the BSP dated October 7, 2007 revealed the client had a goal to "Reduce making false allegations to zero times per month for twelve consecutive months". The review of ABC data at the group home indicated the client made a false allegation on February 5, 2008. The review of ABC data from October 24, 2007 through February 4, 2008 revealed no false allegations at the group home. The review of data documented on "Monthly Psychiatric Visit and Psychotropic Medication Reviews" revealed no false allegations from October 2007 through January 2008.</p> <p>2. A memorandum dated February 12, 2008 on analysis of raw data at the day treatment program revealed the client made 43 false allegations during the month of January 2008. Data</p>	W 252	<div style="border: 1px solid black; padding: 5px;"> <p>W 252, 1 Staff have be trained on accurate collection of data.</p> <p>The facility shall on a monthly basis present behavior data sheets from the residential facility and the day program to the psychiatrist during monthly visit, and at the time of psychotropic medication review.</p> </div>	04/09/08

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W 252	<p>Continued From page 10</p> <p>collection revealed the client made an average of 2.2 false allegations each day at his day treatment program. Interview with the case manager at the day treatment program on February 28, 2008 revealed the client had a large number of false allegations because all false allegations were documented at the day program.</p> <p>Interview with the QMRP revealed he went to Client #1's day program on February 27, 2008 after the investigations concluded, to discuss actions taken by the day treatment program to address the allegation of abuse on February 17, 2008. The meeting summary indicated that the QMRP mentioned that Client #1 had also alleged to the group home staff that someone had touched him inappropriately at his day program. Record review revealed no documentation of these alleged incidents to ensure an accurate monitoring of the client's targeted behavior and/or for follow-up by the interdisciplinary team.</p> <p>3. Interview with the Qualified Mental Retardation Professional (QMRP) and direct care staff on February 28 and February 29, 2008 indicated that Client #1 often made false allegations (untrue statements) about others and situations. Further interview with the QMRP indicated when questioning determined that his statements were false, the Behavior Support Plan (BSP) did not require the allegation to be documented. According to the BSP dated October 1, 2007, staff should ask the client if he is certain the allegation is true. If he said the allegation is not true, staff should thank him for being truthful. Nothing else should be said about the incident.</p> <p>The review of the functional assessment in the BSP however revealed "Staff should document all</p>	W 252	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <p>W 252, 2 Cross Reference W252, 1</p> </div> <div style="border: 1px solid black; padding: 5px;"> <p>W 252, 3 Cross reference W 252, 1</p> </div>	<p>04/09/08</p> <p>04/09/08</p>	

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W 252	Continued From page 11 allegations, regardless of staff's opinion about their truthfulness....Allegations will continue to be treated seriously and investigated." There was no evidence the group home documented all allegations, as recommended by the psychologist in the client's behavior support plan. [See also W189]	W 252		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the need of Client #1. The finding includes: During the telephone call to the Department on Health on February 19, 2007, the day program reported that Client #1 alleged that he had been touched on his buttocks continuously by a peer during the night on February 17, 2008. The review of the day treatment program investigative report revealed that the client made the allegation at approximately 2:45 PM on February 18, 2008. Interview with Client #1's day treatment program case manager indicated that he notified the Qualified Mental Retardation Professional at approximately 3:30 PM on February 18, 2008 of the allegation. Interview with the Licensed Practical Nurse at the day program on February 27, 2008 revealed he examined the client on February 19, 2008 at 9:25 AM and completed an Intra-Agency Communication form, which he forwarded to the group home nurse on that	W 331	W 331 In the future, the facility's Registered Nurse (RN) shall adhere to Wholistic's policy of immediately notifying a client's primary care physician of an unusual incident. The administration will continue to bring this policy to the attention of the Interdisciplinary Team (IDT) on a quarterly basis.	04/09/08

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W 331	<p>Continued From page 12 afternoon.</p> <p>Interview with the facility's Registered Nurse (RN) on February 29, 2008 at 11:13 AM via telephone indicated that she assessed Client #1 after he returned from his day treatment program. Further interview with the nurse indicated that she did not question the client concerning his allegation. Record review revealed a nursing progress note dated February 19, 2008 at 5:10 PM. The client was reported to be in a good mood and to have talked incessantly. The nurse's " head to toe " physical assessment revealed nothing abnormal. The examination of the client's skin in his perineal area revealed it was intact and without redness. The nurse's questioning of the client indicated that he was voiding and having bowel movements without problem. Although a nursing assessment was conducted and further investigation of the allegation was recommended, there was no evidence the primary care physician was informed of the client's allegation.</p>	W 331		

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R 000	<p>INITIAL COMMENTS</p> <p>On February 19, 2008 at approximately 10:10 AM this office received a complaint via telephone from the United Cerebral Palsy of Washington and Northern Virginia Adult Services Day Treatment Facility (UCP). The complainant reported that Resident #1 alleged that he was touched on his buttocks continuously by a peer during the night of February 17, 2008. At 11:53 AM, UCP forwarded an unusual incident report (URI) summarizing the allegation.</p> <p>An onsite visit was initiated on February 27, 2008. The findings of the investigation were based on observations at the group home and the day program, interviews with staff at the group home and the day program, as well as a review of records from October 1, 2007 through February 28, 2008. The findings of the investigation revealed that Resident #1's allegation of being inappropriately touched by a peer at his group home was unsubstantiated. During the investigation, however standard level deficiencies were identified.</p>	R 000		
R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees have worked or resided</p>	R 125		

Health Regulation Administration

M. White

V. and Cheryl

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

4/14/08
(X6) DATE

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If continuation sheet 1 of 2

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R 125	<p>Continued From page 1</p> <p>within the seven (7) years prior to the check for one direct care staff.</p> <p>The finding includes:</p> <p>Interview with Direct Care Staff #1 on February 28, 2008 revealed that he had been working at the facility for several weeks. Interview with the Qualified Mental Retardation Professional (QMRP) indicated that the administrative office would provide the files on February 29, 2008. The review of the requested personnel files no criminal background check was available for Staff #1. Interview with the Residential Manager on February 29, 2008 revealed she was informed by the administrative office that the criminal background check had been done, however the agency was waiting for the results. Record review revealed a job description for Staff #1 which was dated February 7, 2008. There was no evidence the GHMRP ensured a criminal background check for each staff prior to their beginning work in the group home.</p>	R 125	<p>R 125</p> <p>In the future, the GHMRP shall ensure that criminal background checks in all jurisdictions are done for the previous seven (7) years prior to hiring. The Administration of Wholistic Services now has access to online criminal background checks which will make the process faster. The Human Resource (HR) branch of Wholistic is responsible for this task in order to ensure compliance.</p>	04/09/08	