

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

002/033
PRINTED: 08/01/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
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NAME OF PROVIDER OR SUPPLIER WHOLESALE DRUG	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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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) COMPLETION DATE
W 00	GENERAL COMMENTS	W 000		
W 124	<p>489.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent of the client (if a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of three clients included in the sample. (Client #1 and #3)</p> <p>The findings include:</p> <p>1. During the medication pass on 7/17/07 at</p>	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Vice President (X6) DATE: 8/10/07

Deficiency categories ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safety and health are not in jeopardy. (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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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7633 12TH STREET, NW WASHINGTON, DC 20012
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W 124	<p>Continued From page 1</p> <p>8:44 PM, Client #1 was administered Clonazepam 2 mg and Clomipramine HCL 75 mg crushed into applesauce by mouth. Interview with the Trained Medication Nurse (TME) on the same day at approximately 6:50 PM revealed that the medication was prescribed for maladaptive behaviors. Review of the client's physicians orders dated 7/2/07 on 7/18/07 at approximately 9:22 AM revealed that Clomipramine HCL 75 mg 1 cap BID and Clonazepam 2 mg was incorporated in a Behavior Support Plan (BSP) dated 2/5/07, to address behaviors associated with property destruction, self-injurious behavior, scream/yelling/crying/falling to the floor, and trichotillomania.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on 7/17/07 at approximately 10:00 AM revealed that Client #2 did not have a legal guardian and/or involved family members. Review of Client #1's Psychological Assessment dated 7/16/06 on 7/18/07 at approximately 2:41 PM revealed that she was not competent to make independent decisions on her behalf or provide meaningful input into decisions regarding her habilitation planning, placement, treatment, financial, or medical matters. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.</p> <p>b. Review of the Client #1's current physician's order dated 7/2/07 on 7/18/07 at approximately</p>	W 124	<p>Provider has made several attempts to ascertain guardianship. All former requests have been sent to DDS. Provider has sent a copy of this plan to case manager. Provider will continue to request guardianship and document accordingly.</p>	8/10/07

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W 124	<p>Continued From page 2</p> <p>9:22 AM revealed an order 5/15/07 to give six (6) mg of Ativan PO one hour prior to GYN appointment. Further record review failed to evidence that consent had been obtained prior to the administration of the medication on 5/21/07 per the medication administration record. Interview with the Qualified Mental Retardation Professional (QMRP) 7/17/07 at approximately 10:00 AM revealed that Client #2 did not have a legal guardian and/or involved family members. Further interview with the QMRP revealed that Human Rights Committee (HRC) had approved the use of the sedative medications prior to the implementation.</p> <p>2. During the medication pass on 7/17/07 at 6:34 PM, Client #3 was administered Mirtazepine 15 mg, Nefazodine HCL 100 mg, and Zyprexa 5 mg. Interview with the TME on the same day at approximately 6:40 PM revealed that the medication was prescribed for maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on 5/23/07 at approximately 11:12 AM revealed that Client #3 did not have a legal guardian, but has a sister that lived in the virgin islands. The QMRP indicated that they have made numerous phone calls and written letters, but have not been able to contact the sister. Review of Client #3's Psychological Assessment dated 5/15/06 on 7/18/07 at approximately 11:59 AM revealed that the client did not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, and medical matters. There was no documented evidence that the facility informed Client #4 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with</p>	W 124		

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W 124	Continued From page 3 the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance with identifying a surrogate decision-maker for habilitation and treatment needs, for two of three clients included in the sample. (Client #1 and #3) The findings include: The facility failed to ensure clients' rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions regarding their treatment. (See W124)	W 125	See 124	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.	W 130	The facility will ensure privacy for treatment Additional training is scheduled for the 19th of August	8/19/07

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W 130	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the right to privacy during treatment and personal needs, for five of six clients residing in the facility. (Client #1, #2, #3, #4, and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> On 7/17/07 at 4:31 PM, Client #1 pants was partially down, exposing the crevice between her buttocks. At no time did direct care staff encourage Client #1 to pull her pants. On 7/17/07 at 4:50 PM Client #4 was observed with her pants down to her knees as he exited the bathroom. At the time of the survey, the facility failed to ensure the client's privacy after personal needs. The facility failed to ensure that clients received privacy during the evening medication administration as evidence below. <ol style="list-style-type: none"> During the evening medication administration on 7/17/07 at 6:08 PM, the Trained Medication Employee (TME) was observed administering medications to Client #2, in the kitchen in front of #4. Clients #2, #3, #4, and #6 was observed to receive their evening medications administered by the TME in the kitchen area with the blinds open. Further observations revealed that you could see into the next door neighbors home from where the medications were being administered. Interview with the TME indicated that she should have had the blinds down during the 	W 130	<p>Staff will be trained on all aspects of privacy as pertained to all persons in the facility</p>	8/19/07

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W 130	Continued From page 5	W 130		
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure it's policy on Humans Rights Committee (HRC) was implemented, as written.</p> <p>The findings:</p> <p>The facility's Human Rights Committee (HRC) failed to provide evidence of approval for continued use of specific medications as behavioral intervention for the clients as evidenced below:</p> <p>During the medication administration at 6:08 PM, Client #1 was observed to receive Risperdal 5 mg, Trazopine HCL 100 mg. Client #2 received Clonazepam 2 mg and Clomipramine HCL 75 mg at 6:44 PM. Client #3 received Mirtazepine 15 mg, Nefazodine HCL 100 mg, and Zyprexa 5 mg at 6:34 PM. Interview with the Trained Medication Employee (TME) revealed that the medications were prescribed to manage the clients' maladaptive behaviors.</p> <p>Review of the facility's HRC minutes conducted on 7/17/07 at 1:42 PM revealed that the HRC had approved updated Behavior Support Plans for all three clients; however, the minutes failed to show</p>	W 149	<p>HRC shall incorporate in the HRC minutes specific approval of psychotropic medications on quarterly basis.</p>	8/10/07

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W 149	<p>Continued From page 6</p> <p>evidence of the approval of the use of psychotropic medications.</p> <p>Interview with the facility's Registered Nurse (RN) on July 19, 2007 at 3:30 PM revealed the client had been receiving the medications for some time and that the use of the medications was reviewed by the facility's HRC when they were initially prescribed; however, the facility was no able to produce the initial HRC minutes were the medications were approved. The RN further revealed that she was unaware that the HRC was required to review the continued use of the psychotropic medications after they were initially approved. The RN indicated that Behavioral Intervention Committee (BIC) reviews the prescribed psychotropic medications monthly.</p> <p>According to the facility's HRC policy, the function of the HRC is to review behavior policies, procedures, specific interventions and concerns to ensure the rights of the individuals receiving treatment. In particular, all individual behavior intervention programs including the use of restrictive procedures must be approved by the HRC and reviewed by that committee.</p>	W 149		
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, interview and record review the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the</p>	W 159	<p>Each person's active treatment program will be integrated coordinated and monitored by the AMRP. Employees will receive continuous training in documenting on IPP data collection form.</p>	8/10/07

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W 159	<p>Continued From page 7</p> <p>Qualified Mental Retardation Professional (QMRP).</p> <p>The findings include:</p> <ol style="list-style-type: none"> The QMRP failed to ensure that each employee had initial and continuing training in documenting on Client #3's Individual Program Plan (IPP) Data Collection Form. [See W189] The QMRP failed to ensure Client #1 was provided opportunities for continuous active treatment in accordance with her IPP. [See W249] The QMRP failed to ensure that data had been collected in accordance with the IPP for Client #3, which was necessary for a functional assessment of the client's progress. [See W252] The QMRP failed to revise the program objective after the client successfully completed an objective. [See W255] The QMRP failed to ensure that the Human Rights Committee (HRC) attendance a meeting included persons with no ownership or controlling interest in the facility. [See W261] The QMRP failed to ensure programs which incorporate restrictive techniques and use of behavior modification were conducted only with written informed consent. [See W263] The QMRP failed to ensure that fire evacuation drills were held under varied conditions. [See W441] 	W 159	<p>The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of all persons served. All individual behavior intervention programs including the use of restrictive procedures will be reviewed and approved by the HRC and will be documented to that effect. At least quarterly.</p> <p>See w189 See w249 See w252 See w255 See w261 See w263 See w441</p>	8/10/07

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AND PLAN OF CORRECTION

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IDENTIFICATION NUMBER:

09G175

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

07/19/2007

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7633 12TH STREET, NW
WASHINGTON, DC 20012

WHOLISTIC 08

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W 159	<p>Continued From page 8</p> <p>8. The QMRP failed to coordinate with the psychologist to address Client #2's frequent behavior of throwing her compact disk (CD) player.</p> <p>Interview with direct care staff on July 17, 2007 indicated that the client did not know how to operate the CD player but enjoys listening to music. The client was observed on 7/17/07 to wear headphones while listening to her portable CD player. The client was further observed to throw her CD player to the floor several times as listed below:</p> <p>4:40 PM - Client #2's 1:1 staff put the headphones on her and gave her the CD player. Client #2 immediately threw the CD player in the direction of Client #3. Staff picked up the CD player from the floor and returned it to the client.</p> <p>5:57 PM - Client #2 was again observed wearing headphones and appeared to be listening to her portable CD player for approximately two minutes. She then threw the CD player across the living room. The staff gave the CD player back to the client.</p> <p>6:45 PM - Staff gave Client #2 her head phones and her CD Player. Client held it about 2 minutes, then threw it across the room. Staff gave it back to her and she held it for a few minutes.</p> <p>6:51 PM - Client threw her CD Player approximately 10 feet across the room.</p> <p>Interview with the QMRP on July 19, 2007 3:15 PM revealed the client sometimes breaks her CD Player when she throws it on the floor. There was no evidence that this behavior had been reported</p>	W 159	<p>Present at all HRC meetings. QMRP will coordinate with psychologist to address individual's frequent behavior of throwing her compact disk player</p> <p>All findings will be incorporate into SSP and staff trained accordingly.</p>	8/19/07

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W 159	Continued From page 9 to the psychologist.	W 159	<p><i>Current license will be on file for each professional program staff please see attached.</i></p>	8/10/07
W 170	<p>483.430(b)(5) PROFESSIONAL PROGRAM SERVICES</p> <p>Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all professionals licenses were available for review and verification.</p> <p>The findings include:</p> <p>Review of personnel records on 7/19/07 at 10:37 AM revealed the professional licenses for the psychiatrist and psychologist were not available for review. At the time of the survey, there was no evidence that the psychiatrist and psychologist were currently licensed in accordance with the Health Occupation Revision Act (HORA), Title 3 Chapter 12, Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")</p>	W 170		
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each employee was</p>	W 189	<p><i>The facility will provide each employee with training. Training scheduled on 8/17th of August.</i></p>	8/19/07

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W 189 Continued From page 10
provided with initial and continuing training that enables the employee to perform duties competently for two of three clients included in the sample. (Clients #2 and #3)

The findings include:

1. The facility failed to ensure each staff assigned to provide 1:1 supervision to Client #2 was trained on the 1:1 protocol. Interview with the staff assigned to provide 1:1 supervision to Client #2 on July 17, 2007 revealed she was the client's substitute staff. Interview with the Qualified Mental Retardation Professional (QMRP) revealed it was this staff's second day working at the facility. Further interview with the QMRP indicated the staff had not received initial training on the client's BSP and 1:1 supervision protocol. Record review revealed a BSP dated September 8, 2006 which includes 1:1 Staff Person Tasks and Duties.
2. The facility failed to ensure that each employee had initial and continuing training in documenting on Client #3's Individual Program Plan Data Collection Form. [See W252]

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.

*P#10
See front
W 249*

W 189 *Staff assigned to provide 1:1.*

W 249 *Each individuals will receive a continuous active treatment program.*

8/10/07

8/14/07

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W 249	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPP) for one client in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure the implementation of Client #1's Individual Program Plan (IPP) that addressed training on hand washing as evidenced below:</p> <p>Review of the Individual Program Plan (IPP) dated 7/17/07 on 7/18/07 at approximately 10:28 AM, revealed Client #1 had an objective which read "will wash her hand before dinner given verbal assistance 65% of trials". Observations conducted at approximately 5:24 revealed Client #1 sitting in the reclining chair. The client was then observed to get off out of the chair and walk around the interior of her home into the dining area. Observation at 5:31 PM, revealed the client was sitting at the dining table preparing for her dinner meal. Dinner was served at approximately 5:37 PM.</p> <p>Interview with the House Manager (HM) on 7/18/07 at 3:05 PM revealed that Client #1 should wash her hands before dinner daily as part of her IPP. The HM indicated that several new direct care staff had come aboard recently.</p>	W 249	<p>Consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objective identified in the IPP plan. Staff has been trained to ensure implementation.</p>	8/10/07
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</p>	W 252	<p>Staff will be trained so that data relative to accomplishment of</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2007
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7632 12TH STREET, NW WASHINGTON, DC 20012
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W 252	<p>Continued From page 12 terms.</p> <p>This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was collected in the form and required frequency for one of three clients included in the sample. (Client #3)</p> <p>The findings include:</p> <p>The facility failed to ensure that data had been collected in accordance with the IPPs for Client #3, which was necessary for a functional assessment of the client's progress as evidenced below:</p> <p>a. Evening observations conducted on 7/17/07 at 4:46 PM revealed Client #3 sitting at the dining table with peers and staff. The client was observed identify various coins and recognize a one dollar bill. Review of the client's Individual Program Plan (IPP) dated 7/17/06 revealed a program objective which read "will independently identify a one dollar bill, a quarter, a dime, a nickel, and a penny 75% of the trials recorded daily. Further review of the data collection revealed no documentation data for the entire month of July 2007. Interview with the Qualified Mental Retardation Professional (QMRP) on 7/18/07 at approximately 3:30 PM acknowledged the lack of documentation for the month of July 2007. The QMRP indicated the staff was recently hired.</p> <p>b. Evening observations conducted on 7/17/07 at approximately 4:50 PM revealed Client #3 sitting</p>	W 252	<p>of the criteria specified in persons IPP objectives will be documented in measurable terms. Documentation shall be timely + accurate.</p>	8/10/07
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W 252	Continued From page 13 at the dining table with peers and staff. The client was observed to identify different colors. Review of the client's Individual IPP revealed a program objective which read "will independently identify her colors (red, blue, green, yellow, and white) 75% of the trials recorded daily". Further review of the data collection revealed documentation had already been completed for the entire month of July 2007. Interview with the QMRP on 7/18/07 at approximately 3:60 PM acknowledged that the documentation for the month of July 2007 had been completely filled out. The QMRP indicated the staff was recently hired. The QMRP also indicated that she would be training all new staff.	W 252		8/10/07
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to revise objectives identified in the individual program plan that had been successfully achieved for one of three clients included in the sample. (Client #3) The finding includes: Client #3's Individual Program Plan (IPP) and related data collection were reviewed on 7/18/07 at 12:55 PM. The client had an IPP objective which read " given verbal assistance, will clean out the microwave 75% of the trials recorded.	W 255	All IPP will be reviewed at least by the QMRP, and revised as necessary. QMRP months notes will specifically address achievement of IPPs.	

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W 255	Continued From page 14 The documentation reflected that during May 2007 and June 2007, the client performed at 100% verbal assistance thus meeting the criterion level. According to the July 2007 documentation, the client continued to perform at 100% verbal assistance as of 7/19/07. Interview with the Qualified Mental Retardation Professional (QMRP) on 7/19/07 at approximately 1:45 PM revealed that, according to the way the objective is written, the client has achieved the goal. There was no evidence the program objective was revised after the client achieved at the stated criterion level.	W 255		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on staff interview and record reviews, the facility failed to ensure that Individual Support Plans (ISPs) had been developed timely for two of the six clients residing in the facility. (Clients #1 and #4). The findings include: 1. During record reviews on 7/18/07 at 2:41 PM, it was identified that Client #1's Individual Support Plan (ISP) developed by the Interdisciplinary Team (IDT) expired on 7/17/07. According to interview with the QMRP on 7/18/07 at 3:15 pm, the expired ISP resulted from recent judicial findings that required the provider to extend the	W 259	upon the order of Judge [redacted] our entire ISP system has changed. This is a systems issue that can not be corrected by any individual provider. please advise.	on-going

ADVICE REQUESTER

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W 259	Continued From page 15 date of this client ' s annual ISP meetings until the court anniversary date.	W 259		
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on this committee. The finding includes: Review of the Human Rights Committee (HRC) meeting minutes was conducted on 7/17/07 at 1:42 PM. According to the HRC minutes dated 12/4/06, Client #3's Behavior Support Plan (BSP)	W 261	The facility will ensure that persons with no ownership or controlling interest in the facility continue to consistently participate on human rights committee. _____ is our representative and has consistently attended our meeting in 2007	8/19/07

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W 281	Continued From page 16 was updated and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present. Interview with the Qualified Mental Retardation Professional (QMRP) on 7/18/07 at approximately 3:05 PM indicated that the facility does have a community representative; however, the representative was not present on that day of the meeting.	W 281		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the committee reviewed individual programs designed to manage inappropriate behavior that involved risks to client protection and rights for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: During the medication pass on 7/17/07 beginning at 8:05 PM revealed that Client #1, #2, and #3 were prescribed and received psychotropic medications. Interview with the facility's nurse on 7/18/07 revealed that the clients had been receiving psychotropic medications for "some time" and that these medications were reviewed by the Human Rights Committee (HRC). Record	W 262	The facility will ensure that the committee reviews individual programs designed to manage inappropriate behavior. that the committee about client protection beights to state. HRC minutes has subsequently been revised to ensure quarterly review.	8/10/07

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W 262	Continued From page 17 review conducted on 7/17/07 revealed that the HRC minutes did not reflect that the clients medications were reviewed and approved. There were no additional HRC minutes to confirm that the clients medications had been approved by the HRC.	W 262		
W 263	<p>483.440(f)(3)(II) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents, for two of three clients included in the sample. (Client #1 and #3)</p> <p>The findings includes:</p> <p>The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Client #1, #2 and #3's Behavior Support Plan (BSP) in conjunction with the use of prescribed psychotropic medications as evidenced below.</p> <p>1. There was no evidence that written consent had been obtained for Client #1's Behavior Support Plan (BSP) and for the use of prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on 7/18/07 at approximately 3:35 PM revealed that Client #1 did not have written</p>	W 263	<p>The Committee shall ensure these programs conducted only with written informed consent of the persons Parents or legal guardians.</p>	8/10/07

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W 263 Continued From page 18
Informed consent signed by a guardian or any other person identified as responsible at the time of the survey; however, the QMRP has submitted paper to obtain guardianship for the client. [See W124]

2. There was no evidence that written consent had been obtained for Client #1's Behavior Support Plan (BSP) and for the use of the prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on 7/19/07 at approximately 3:45 PM revealed that Client #3 did not have written informed consent signed by a guardian or any other person identified as responsible at the time of the survey; however, the QMRP has submitted paper to obtain guardianship for the client. [See W124]

3. During medication administration on July 17, 2007 at 8:08, Client #2 was observed to receive Trazodone HCL 100mg, Risperdal 5 mg, Valproic Acid 1000 mg. Record verification revealed the client was prescribed these medications for maladaptive behaviors. Record review revealed the client has a behavior support plan dated September 7, 2007.

Interview with the QMRP and the record review on July 19, 2007 revealed no evidence that consent had been obtained from the client's guardian for the aforementioned restrictive measures.

W 263
See W 124

W 289 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR

The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program

W 289 *See W 124*

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W 289	Continued From page 19 plan, in accordance with 5493.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on review of the clients' behavioral support plans, the facility failed to ensure that the use of behavioral control medications had been approved by the Interdisciplinary Team and incorporated in the clients ISPs for three of three clients in the sample. (#1, #2, and #3) The findings include: 1. Psychotropic medications administered on July 17, 2007 for Clients #1, #2, and #3 were not included in the behavioral support plans (BSPs). a. Observation of the medication administration conducted for Client # 1 at 6:44 PM revealed that the client received Clonazepam 2 mg and Clomipramine HCL 75 mg crushed into applesauce by mouth. The review of Client #1's individual support plan (ISP) on July 18, 2007 at 2:41PM revealed the psychotropic medications administered was not included in the plan. b. During the observation of the medication administration conducted for Client # 2 beginning at 6:08 PM it was revealed that she received Trazodone HCL 100mg, Risperdal 5 mg, and Valproic Acid 1000 mg. The review of Client #1's ISP on July 18, 2007 at 3:02 PM revealed the psychotropic medications administered were not included in plan. c. Observation of the medication administration conducted for Client # 3 at 6:34 PM revealed that	W 289	<i>The facility will ensure that the use of behavioral controls medication has been approved by the IDT and incorporated in the Person's ISP. Plans will be amended to include medications.</i>	<i>8/10/07</i>

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W 289	Continued From page 20 she received Mirtazapina 15 mg, Nefazodine HCL 100 mg, and Zyraxa 5 mg. The review of Client #3's ISP on July 18, 2007 at 11:59 AM revealed the psychotropic medications administered was not included in the plan.	W 289		
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for two of three clients included in the sample. (Client #1 and #2)</p> <p>The findings include:</p> <p>The facility failed to ensure that medication orders obtained by telephone for Clients #1 and #2 were signed by the primary care physician.</p> <p>1. Verification of Client #2's medication orders on July 18, 2007 revealed she was prescribed a one time dosage of Lorazepam 2 mg tab (2 tabs (4 mg) by mouth on June 13, 2007. Further review of the medication administration record (MAR) revealed the Lorazepam was given as sedation prior to a gynecological appointment on June 18, 2007. Interview with the registered nurse (RN) on July 19, 2007 revealed that the order was obtained from the primary care physician (PCP) by telephone and should have later sign signed by him. At the time of the survey, the telephone order for the Lorazepam had not been signed by the PCP.</p>	W 322	<p>The facility will provide or obtain preventive & general medical care facility will ensure that medication orders^{orders} obtained by telephone for individuals signed by primary care physician. PCP has signed phone orders. missing matters shall address all telephone orders.</p>	8/10/07

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W 322 Continued From page 21
2. Review of the physician's orders revealed Client #2 had a telephone order on October 16, 2006 for Benadryl 25 mg cap at bedtime as needed for sleep. Further review revealed the order was not signed by the PCP. Interview with the RN on July 19, 2007 revealed that the order was obtained from the primary care physician (PCP) by telephone and should have later been signed by him. At the time of the survey, there no evidence the telephone order for the Benadryl 25 mg was signed by the PCP.

W 322

3. Review of the medical records conducted on 7/19/07 at 8:22 AM, revealed a physician's order dated 5/15/07. According to the order, Client #1 was to be administered 6 mg Ativan PO one (1) hour prior to gynecological appointment on 5/21/07. Interview with the RN on 7/19/07 revealed that the telephone order was should have been signed by the PCP. The RN indicated that the PCP usually signs off on all orders during his visits. At the time of the survey, the telephone order for the Ativan had not been signed by the PCP.

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, staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of six clients residing in the facility. (Client #1 and #5)

W 331 The facility will provide clients with nursing services in accordance with their needs. Training will be given to them to ensure accurate stationing medication. 8/19/07

The findings include:

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W 331	Continued From page 22 1. The facility's nursing services failed to ensure the administration of medication in compliance with the physician orders for Client #1. [See W368] 2. The facility's nursing services failed to ensure that medications identified as controlled substances were secured under double lock. [See 381]	W 331	<i>in compliance with the physicians orders see 368 see 381</i>	
W 358	483.480(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for two of three clients in the sample. (Client #2 and #3) The findings include: 1. Record review on July 19, 2007 revealed Client #2 had a dental consultation on February 23, 2006 during which the dentist diagnosed caries of teeth #1, #23 and #30. The dentist recommended that these teeth be extracted under deep conscious sedation. Interview with the Qualified Mental Retardation (QMRP) and the nurse on November 19, 2007 at 3:30 PM revealed the teeth had not been extracted due to the lack of consent to perform	W 358	<i>The facility will ensure comprehensive ensure dental treatment services that includes dental care needed for the relief of pain + infections of teeth + maintenance of dental health no provided in a burst manner. All documentation to show their facility has eliciting consumer will be on file</i>	8/19/07

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W 356	<p>Continued From page 23</p> <p>the procedure. Interview with the QMRP indicated a guardian was obtained for the client, however the guardian immediately resigned. Another guardian was appointed in July 2007 for the client and the extractions were scheduled for September 2007.</p> <p>Record review revealed ongoing documentation in 2006 and 2007 by the nurse and the QMRP reflecting that the client was awaiting approval for the procedure. Although the facility indicated that they were awaiting consent, there was no documented evidence of attempts to obtain consent in the records. At the time of the survey, there was no evidence the client had received timely dental health services.</p> <p>2. Record review conducted on 7/18/07 at 11:15 AM revealed a dental consult dated 5/30/07. The consult indicated follow up for scaling, possible extractions were recommended from the last visit on 9/15/06 for Client #3. The consult further indicated that the patient needs extractions of #6, #24, and #25, needs scaling "Will attempt to fabricate dentures after above recommendations are complete".</p> <p>Interview with the facility's Licensed Practical Nurse (LPN) on 7/18/07 at approximately 3:15 PM revealed that Client #3 saw the dentist on 9/15/06 and it was recommended that the client needs scaling and possible teeth extractions. The LPN further revealed that on 5/30/07, Client #3 received scaling; however, the client continued to need extraction of several teeth. The LPN indicated that signed consent to have the teeth extracted is the hold up from getting the dental services completed. The LPN further indicated that there is an appointment in</p>	W 356	<i>consent attempt</i>	

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PRINTED: 08/01/2007
FORM APPROVED
OMB NO. 0938-0391

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W 358	Continued From page 24 September 2007 to have the dental services completed. Although the facility indicated that they were awaiting consent, there was no documented evidence of attempts to obtain consent in the records. (At the time of the survey, the facility failed to provide evidence that Client #3 received timely dental services.	W 358	Letters have been issued to case management regarding the consent of dental procedures	8/16/07 ✓
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation interview and record review, the facility failed to administer medications in compliance with the physician's order for one of three clients included in the sample. (Client #1) The finding includes: During the evening medication administration observation on 7/17/07 at 6:44 PM, Client #1 was observed to receive Flonase Nasal spray. The Trained Medication Employee (TME) was observed to instill one spray in each nostril while the client lay in the recliner chair. Record verification of the Medication Administration Record (MAR) revealed Client #1 is prescribed to inhale two (2) sprays in each nostril every evening. Review of the current physician's orders dated 7/2/07 revealed Client #1 was prescribed Flonase Nasal (Inhale 2 sprays in each nostril every evening). There was no evidence that the Flonase Nasal Spray was administered as prescribed by the physician.	W 368	The facility will ensure that all medications are administered in compliance with the physician's order training will be provided to ensure that medications are administered in compliance with the physician's order.	8/8/07
W 381	483.460(l)(1) DRUG STORAGE AND	W 381		

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

PRINTED: 08/01/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7833 12TH STREET, NW WASHINGTON, DC 20012
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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) COMPLETION DATE
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W 381	<p>Continued From page 25 RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that medications identified as controlled substances were secured under double lock for two of six clients residing in the facility. (Client #1 and #6)</p> <p>The finding includes:</p> <p>Evening observations conducted on 7/17/07 beginning at 6:08 PM revealed Client #1 and #6 were observed to receive the medication Clonazepam. Interview with the Trained Medication Employee (TME) on the same day at approximately 6:50 PM revealed the facility had no medications that required double locks. Inspection of the nurse's station on 7/18/07 at 2:43 PM revealed that the controlled substance (Clonazepam) was observed Client #1's and #6's baskets. Interview with the facility's Registered Nurse (RN) on the same day at approximately 3:05 PM revealed that the facility does have a lock box inside the medication cabinet. The RN further indicated that the facility keeps a declining inventory of the scheduled IV medications. There was no evidence that the medications were properly secured under double lock.</p>	W 381	<p>All drugs will be stored under proper conditions of security. RN will give necessary training to facilitate.</p>	8/8/07
W 438	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces,</p>	W 438	<p>The facility will furnish, maintain in good repair, and teach individuals to use the PTO -></p>	

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

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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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) COMPLETION DATE
W 436	<p>Continued From page 28 and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure devices and aids identified by the interdisciplinary team as needed by the client were maintained in good repair for one client in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. On July 17, 2007 at 8:05 AM the brake on the left front of Client #2 rollator walker was observed to be broken. The client was observed to use the walker during ambulation throughout the survey. Interview with the Qualified Mental Retardation Professional (QMRP) indicated a request had been submitted to obtain a new walker for the client. The review of the last Physical Therapy (PT) assessment dated July 6, 2006 revealed it is the walker is recommended to ensure the client's safety during ambulation. According to the Individual Support Plan dated July 24, 2006, the walker is recommended for use during ambulation due to the client's unsteady gait. There was no evidence the client's walker was maintained in good repair.</p> <p>2. During environmental observations on July 19, 2007 at 12:10 PM, a raised toilet seat was observed detached from the commode. Interview with the home manager (HM) indicated the seat is used by Residents #1 and #2. Record review on July 6, 2006, revealed the PT recommended a raised toilet seat with rails. According to the HM, a request was made to have the raised toilet seat</p>	W 436	<p>manice informed choices about the use of dentures, eye glasses and all devices identified by the IDT needed by individuals. facility will ensure that rollator ^{walker} maintained with good repair. The raised toilet seat has been secured. ✓</p>	8/9/07

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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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) COMPLETION DATE
W 438	Continued From page 27 secured. At the time of the survey, however the toilet seat was not secured.	W 438	appropriate training will be given to	
W 441	483.470(l)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on 7/17/07 at 9:21 AM revealed that most of the fire drills were conducted via the front and back door exits. Review of the fire drill record revealed exits on the second floor and the basement had not been used at any time. Interview with the Qualified Mental Retardation Professional (QMRP) at approximately 9:40 am revealed that the facility had at least four method of egress. Further interview with the QMRP revealed that the clients primarily used the front and back door exits during the past year. There was no evidence that evacuation drills were held under varied conditions.	W 441	staff to ensure that fire drills are held under verified conditions training be held 8/19/07	8/19/07
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure the implementation of infection	W 455		

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G175

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

07/19/2007

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC 09

STREET ADDRESS, CITY, STATE, ZIP CODE

7833 12TH 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 455

Continued From page 28
control procedures to prevent communicable
infectious diseases for five of the six clients
(Clients #1, #2, #4, #5, and #6) residing in the
facility.

The findings include:

Evening observations conducted on 7/17/07 at
5:40 PM revealed Clients #1, #2, #4, #5, and #6
sitting at the dining table eating their dinner meal.
At no time did direct care staff encourage or
redirect the clients to wash their hands. Interview
with the home manager indicated the client
should wash their hands every day before dinner.
There was no evidence that infections control
procedures to prevent communicable infectious
diseases were being implemented.

W 488

483.480(d)(4) DINING AREAS AND SERVICE

The facility must assure that each client eats in a
manner consistent with his or her developmental
level.

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility
failed to ensure the opportunity was participation
in family style dining was provided for five of the
six clients residing in the facility. (Clients #2, #3,
#4, #5, and #6)

The findings include:

On July 17, 2007 at 5:20 PM, Client # 3 was
observed setting the table. At 5:35 PM the home
manager was observed serving the dinner plates
in the kitchen. Direct staff were observed
escorting Clients #2, #4, and #6 to the kitchen to
get their dinner plates which they were

W 455

Facility will ~~control~~ ^{conduct}
procedures ~~and~~
and training to ensure
preventive communicable
infectious disease mitigated

8/18/07

W 488

Facility will encourage ^{8/18/07}
the opportunity for
participation in family
style dining by the
individuals in that
facility. beginning
8/18/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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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) COMPLETION DATE
W 488	<p>Continued From page 29</p> <p>supervised/assisted to carry back to the dining room table beginning at 5: 37 PM. During this time, Client # 3 was observed carrying her own plate to the dining table. Plates for Clients #5 and #1 were carried to the dining room by staff. During mealtime, the clients were able to feed themselves with supervision. Staff reported that Client #1 was blind; however, she was also able to feed her self with staff supervision.</p> <p>Interview with the Qualified Retardation Professional and the record review on July 19, 2007 at 3:30 PM revealed the clients had not been assessed or provided training to participate in family style dining. Although at snack time the client were offered the opportunity to select from a variety of fruits, there was no evidence that the clients were provided an opportunity to participate in family style dining at meal time.</p>	W 488		

Health Regulation Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 090175	(12) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(13) DATE SURVEY COMPLETED 07/19/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 08		STREET ADDRESS, CITY, STATE, ZIP CODE 7205 15TH STREET, NW WASHINGTON, DC 20012	

(14) ID PREFIX TAG	PRIMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(15) PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(16) COMPLETE DATE
R 128	<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 CHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions who have worked or resided within the seven (7) years prior to the check.</p> <p>The finding includes: Review of the personnel files on 7/18/07 at 9:37 AM revealed the CHMRP failed to evidence criminal background checks for eight of eleven staff for the state of Maryland in which they reside: (S1, S2 S5, S8, S7, S9, S3, S10, and S11)</p>	R 128	<p>Criminal Background checks have been submitted for all person to private contractor. Outcomes should be received by provider within 10 days</p>	8/18/07

HEALTH REGULATION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *M. Little Jones* TITLE: *Vice President* DATE: *8/11/07*

STATE FORM 1000 (11-2003) RLD011 If continuation sheet 1 of 1

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2007
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 88	STREET ADDRESS, CITY, STATE, ZIP CODE 7825 18TH STREET, NW WASHINGTON, DC 20018
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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
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1000 INITIAL COMMENTS

This licensure survey was conducted from July 17, 2007 through July 19, 2007. A fundamental survey was conducted. A random sample of three clients was selected from a residential population of six females with varying degrees of mental retardation. Five of six clients in the facility had psychiatric diagnoses for which medications were prescribed.

The findings of this survey based on observations at the residence and day program, staff interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports and policies.

1000

1077 3803.5 BEDROOMS AND BATHROOMS

Each bedroom shall contain sufficient storage space for each resident's seasonal, personal clothing and personal effects.

This State is not met as evidenced by: Based on observation, interview and record review, the CHMRRP failed to ensure the bedroom contained sufficient storage space for each resident's clothing.

The findings include:

Observations of the residents' bedrooms on July 18, 2007 beginning at 12:15 PM revealed the following concerns:

1. Clothing were observed on the shelf above the hanging rack in the closet in the bedroom of Residents #4 and #5. No device was available to clearly separate the clothing of the two residents.

1077

The CHMRRP will work ensure that the bedroom contains sufficient storage space for each individual's clothing.

8/18/07

Health Regulation Administration	TITLE	(X6) DATE
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		
STATE FORM 500	ALD011	Revised 10/01/06 1 of 10

Health Regulation Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09C178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC OS		STREET ADDRESS, CITY, STATE, ZIP CODE 7922 12TH STREET, NW WASHINGTON, DC 20012		

(X4) ID PREFIX TAG	BRIEF 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)	DATE COMPLETE
1077	Continued From page 1 2. Resident J's purses were observed stored in a bag on top of her wardrobe and not easily retrievable by the resident. 3. The inset for securing the drawers of Resident 69's nightstand in an upright position when open was missing. This caused the drawers to hang downward when opened. Interview with the home manager and the Qualified Mental Rehabilitation Professional revealed that new storage units had been ordered for the residents. The review of a purchase request for bedroom dressers dated March 20, 2007 revealed the request was approved by the department head and the administrator on that date. At the time of the survey, there was no evidence the dressers were available to ensure enough storage space was available for the clients' belongings.	1077		
1080	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 interview, the GHMRP failed to ensure the interior and exterior of the facility were maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: Observation of the environment on July 19, 2007	1080	The interior and exterior of each GHMRP facility will be maintained in a safe, clean, orderly, attractive & sanitary manner and be free of accumulations of dirt, rubbish, & objectionable odors.	

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(7) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 092178	(8) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(9) DATE SURVEY COMPLETED 07/19/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 88		STREET ADDRESS, CITY, STATE, ZIP CODE 7898 12TH STREET, NW WASHINGTON, DC 20012		
(6) IS PREP TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(5) PREP TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(4) COMPLETE DATE
1080	Continued From page 2 beginning at 12:06 PM revealed the following concerns. 1. Observation of the entrance to the basement from the first floor hallway revealed no door was installed. Observation of the door frame revealed the hardware for securing a door in place were still attached. Interview with the maintenance supervisor on July 17, 2007 at 2:38 PM revealed he had not observed a door at the entrance to the basement from the first floor of the GHMRP. 2. Observation of the basement exit door revealed a crack approximately 1/8 inch wide between the door frame and the edge of the door at the bottom left side. Further observation revealed light was visible from the outside. 3. Observation of the light fixture at the top of the basement stairs on July 17 and July 18, 2007 revealed a light socket which contained no bulb. 4. The door in the sitting room which leads to the attic stairs was observed open. Attempts to secure the door were unsuccessful. 5. The bathroom on the second floor, in which the shower was located, had a switch plate that was easily movable when pressure was applied. 6. The bathroom in which tub was located had a broken front left edge on the water tank. This exposed sharp edges. 7. Caulking securing the bath tub to the wall was cracked. 8. The air conditioner in the window of the bedroom of Residents #1 and #2 had an accumulation of dust. Record review revealed	1080	All repairs will be done effective examination will continue for the prevention of two reaches	8/19/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000178	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC DS		STREET ADDRESS, CITY, STATE, ZIP CODE 7828 15TH STREET, NW WASHINGTON, DC 20018	

(X4) ID PREFIX TAG	BRIEF 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	Continued From page 3 that Client #2 is allergic to dust mites. 6. Window interiors of the bedroom contained operational seal. 10. The toilet tissue holder was not secured in the basement bathroom. 11. The paper towel holder was broken in the basement bathroom. 12. The door latch in the basement was secured to a screw. 13. The corner in the basement bathroom where items were stored had no light. 14. A board on the wall where it meets the floor was not secured to the the wall. 15. The basement bathroom lacked a source of ventilation. The window was sealed closed and there was no mechanical ventilation. 18. Ineffective vermin control was observed at the facility. On 7/17/07 at 8:45 AM, a live roach was observed crawling on the floor of the basement bathroom. On 7/19/ 2007 at 12:45 PM a live roach was observed crawling on the dining room floor. Interview with the QMRP revealed that the facility has an pest control contract and that the most recent extermination was conducted on 7/17/07. There was no evidence the exterminations had been effective for the prevention of live roaches in the facility. Exterior 1. The railing located on the right side of the front porch was not secured to the concrete floor. The railing had a heavy accumulation of rust and had	1000		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(P1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

090178

(02) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(03) DATE SURVEY
COMPLETED

07/18/2007

NAME OF PROVIDER OR SUPPLIER

WHOLISTIC DS

STREET ADDRESS, CITY, STATE, ZIP CODE

7555 18TH STREET, NW
WASHINGTON, DC 20012

(04) ID
PREFIX
TAB

BRIEF STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

(05) PREFIX
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PROVIDER'S PLAN OF CORRECTION
(EAC: CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(06) COMPLETE
DATE

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Continued From page 4
became detached.
2. Parallel downspouts were observed on the right side of the front porch. No device was available to divert water from the downspouts away from the foundation of the house.
3. The dryer vent cover was observed to be missing from the wall at the rear of the facility.
4. A hole was observed in the window of the basement storage room.
5. An unsecured board was observed at front right side of the bottom step leading from the back porch.
6. One of the large trash cans located in the back yard had a broken lid. The lid was approximately two inches narrower than top of the trash can.

1 000

1 185

3006.6 FIRE SAFETY
Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.
This statute is not met as evidenced by:
Based on staff interview and record verification, the GHMRP failed to hold evacuation drills under varied conditions.
The finding includes:
Review of the facility's fire drill records on 7/17/07 at 9:21 AM revealed that most of the fire drills were conducted via the front and back door exits. Review of the fire drill record revealed exits on the second floor and the basement had not been

1 185

From:
Staff will be trained and fire evacuation drills will be held under varied conditions - Staff training scheduled, for 8/18/07

8/18/07

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080178	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 07/18/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC DC		STREET ADDRESS, CITY, STATE, ZIP CODE 788 12TH STREET, NW WASHINGTON, DC 20012		
CCO 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)	DATE COMPLETE DATE
1155	Continued From page 6 used at any time. Interview with the Qualified Mental Retardation Professional (QMARP) at approximately 9:40 am revealed that the facility had at least fair method of egress. Further interview with the QMARP revealed that the clients primarily used the front and back door exits during the past year. There was no evidence that evacuation drills were held under varied conditions.	1155		
1204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment. This statute is not met as evidenced by: Based on record review, the QMARP failed to have on file for review current job descriptions for all new employees. The findings include: Review of the personnel files on 7/18/07 at 8:27 AM, the QMARP failed to provide current job descriptions for three new employees who had been employed. (88, 85, and 88).	1204	All employees will be given a copy of his or her job descriptions to review upon employment	8/18/07
1208	3509.8 PERSONNEL POLICIES 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.	1208	Each employee prior to employment and annually thereafter shall provide a physician's current health certificate	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080173	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 07/19/2007
NAME OF PROVIDER OR SUPPLIER WHOLEISTIC DO		STREET ADDRESS, CITY, STATE, ZIP CODE 7558 15TH STREET, NW WASHINGTON, DC 20012		
DCS 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)	COM COMPLETE DATE
1 808	Continued From page 5 This statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The finding includes: Review of personnel records on 7/16/07 at 10:30 AM revealed no documented evidence of current health certificates for consultant: [011]	1 204	to allow him or her to perform the required duties. All current health certificates will be on file	8/18/07
1 227	3510.8(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Infection control for staff and residents; This statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees. The findings include: On 7/19/07, review of personnel records/training records revealed that the following staffs were without current First Aid and CPR, or both. a. First Aid - 83 and 87 b. CPR - 83 and 87	1 227	Facility will ensure that all training certificates for First Aid and CPR for employees are current on file	8/18/07
1 379	3510.10 EMERGENCIES In addition to the reporting requirement in 3510.8, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially	1 379	The facility will notify the Dept. of Health and all other agencies of any	8/18/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	DC1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 089175	DC2) MULTIPLE CORRECTION A. BUILDING _____ B. WING _____	DC3) DATE SURVEY COMPLETED 8/11/07
NAME OF PROVIDER OR SUPPLIER WHOLELIST'S DI		STREET ADDRESS, CITY, STATE, ZIP CODE 7599 12TH STREET, NW WASHINGTON, DC 20012	

DC4) 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)	DC5) COMPLETE DATE
1379	<p>Continued From page 7</p> <p>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 of the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to report unusual incidents within twenty-four (24) hours of the next work day.</p> <p>The findings include:</p> <p>Unusual incidents were review at the GHMRP on July 17, 2007 beginning at 9:00 AM. Interview with the Qualified Marital Retardation Professional (QMRP) and review of records revealed the following information:</p> <p>1. Review of an unusual incident report dated July 8, 2007 revealed at 4:30 PM, staff informed the registered nurse (R.N.) that Client #E was observed exhibiting awkwardy. The nurse observed swelling of the resident's right ankle. This area was warm to touch and an old abrasion, scar was noted on the right lateral side of her ankle. The Primary Care Physician was notified for medical follow-up. Interview with the RN on July 18, 2007 and record review revealed an x-ray conducted on July 8, 2007 concluded soft tissue swelling. The GHMRP's internal investigation dated July 8, 2007 indicated the origin of the resident's injury remained unknown. At the time of the survey, there was no evidence the incident was reported to the Department of Health.</p>	1379	<p>Unusual incident by telephone immediately & shall be followed up by written notification within 24 hrs of the next work day please see protocol.</p>	8/11/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080178	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED 07/18/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC DC		STREET ADDRESS, CITY, STATE, ZIP CODE 7223 18TH STREET, NW WASHINGTON, DC 20012	

(A) IS PREP 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)	(C4) COMPLETE DATE
1578	Continued From page 8 2. Interview with the CMRP revealed Residents #1, #2, #4, #5, and #6 were involved in a motor vehicle accident on January 11, 2007. The review of Resident #2's medical record on July 18, 2007 revealed an emergency room report dated January 11, 2007. The CMRP indicated the residents were taken to the emergency room as a precautionary measure, however were determined to have no injuries. The CMRP indicated that the unusual incident report it was not available. The RN confirmed an unusual incident report was completed. At the time of the survey, there was no evidence the incident was reported to the Department of Health.	1578		
1577	3820.2(g) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (g) Psychology: This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file current licenses for all consultants. The finding includes: Review of the personnel files on 7/18/07, revealed the facility failed to provide a current	1577	The facility will ensure that all licenses are on file for consultants 8/10/07	

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(A) PROVIDER/UNIVERSITY
IDENTIFICATION NUMBER

(B) MULTIPLE CONSTRUCTION

(C) DATE SURVEY
COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

07/18/07

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7655 15TH STREET, NW
WASHINGTON, DC 20012

(A) ID
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(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

(B)
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(C)
COMPLETION
DATE

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Continued From page 8
losure for the O7 and O11 at the time of the
survey,

1367

1432

3821.3 HABILITATION AND TRAINING

Each QHMRP shall provide habilitation, training
and assistance to residents in accordance with
the resident's Individual Habilitation Plan.

This Statute is not met as evidenced by:
Based on interview and record review, the
QHMRP failed to ensure habilitation, training and
assistance were provided to Resident #1 in
accordance with his Individual Habilitation Plan.

1432

Facility will
provide habit-
uation training
and assistance
in accordance
with the
individual's
IHP.
Training will
be provided
to staff to
ensure the
implementation
of individual's
IHP.

8/18/07

The finding includes:

The facility failed to ensure the implementation of
Resident #1's Individual Program Plan (IPP) that
addressed training on hand washing as
evidenced below:

Review of the Individual Program Plan (IPP)
dated 7/17/07 on 7/18/07 at approximately 10:20
AM, revealed Resident #1 had an objective which
read "will wash her hand before dinner given
verbal assistance 85% of trials". Observation at
5:31 PM, revealed the resident was sitting at the
dining table preparing for her dinner meal.
Dinner was served at approximately 5:37 PM.

Interview with the House Manager (HM) on
7/18/07 at 3:08 PM revealed that Resident #1
should wash her hands before dinner daily as
part of her IPP. The HM indicated that several
new direct care staff had come aboard recently.

1434

3821.6(a) HABILITATION AND TRAINING

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000176	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED 07/19/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC OR _____		STREET ADDRESS, CITY, STATE, ZIP CODE 7833 18TH STREET, NW WASHINGTON, DC 20018			
(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LHA IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETE DATE	
1424	<p>Continued From page 10</p> <p>Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client:</p> <p>(a) Has successfully completed an objective or objectives identified in the individual Habilitation Plan;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure program revisions were made at least every six months or when a resident successfully completed the objective.</p> <p>The finding includes:</p> <p>Resident #8's Individual Program Plan (IPP) and related data collection were reviewed on 7/18/07 at 12:55 PM. The resident had an IPP objective which read "given verbal assistance, will clean out the microwave 75% of the trials recorded. The documentation reflected that during May 2007 and June 2007, the resident performed at 100% verbal assistance thus meeting the criterion level. According to the July 2007 documentation, the resident continued to perform at 100% verbal assistance as of 7/19/07.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRF) on 7/19/07 at approximately 1:45 PM revealed that, according to the way the objective is written, the resident has achieved the goal. There was no evidence the program objective was revised after the resident achieved at the stated criterion level.</p>	1424	<p>QMRF will ensure that modifications to individual program at least every six months or when the individual has successfully completed an objective identified in the IPP. QMRF shall address this.</p>	8/18/07	
1470	<p>3622.1 MEDICATIONS</p> <p>Drugs shall be administered as set forth in the User Of Trained Employees to Administer</p>	1470			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(21) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 080178	(22) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(23) DATE SURVEY COMPLETED 07/18/07
NAME OF PROVIDER OR SUPPLIER WHOLISTIC CB		STREET ADDRESS, CITY, STATE, ZIP OR DC 7608 18TH STREET, NW WASHINGTON, DC 20012		

(24) ID PREFIX TAG	BRIEF STATEMENT OF DEFICIENCY (Each deficiency must be preceded by full regulatory or LSC identifying information)	ID PREFIX TAG	PROVIDER PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)	(25) COMPLETE DATE
1472	<p>Continued From page 11</p> <p>Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1984, D.C. Code, sec. 21-1201 et seq.</p> <p>This Statute is not met as evidenced by: Based on observation interview and record review, the GHMRP failed to administer medications in compliance with the physician's order for one of three residents included in the sample that received medications. (Resident #1)</p> <p>The finding includes: During the evening medication administration observation on 7/17/07 at 6:44 PM, Resident #1 was observed to receive Flonase Nasal spray. The Trained Medication Employee (TME) was observed to instill one spray in each nostril while the client lay in the recliner chair. Record verification of the Medication Administration Record (MAR) revealed Resident #1 is prescribed to inhale two (2) sprays in each nostril every evening. Review of the current physician's orders dated 7/2/07 revealed Resident #1 was prescribed Flonase Nasal (Inhale 2 sprays in each nostril every evening). There was no evidence that the Flonase Nasal Spray was administered as prescribed by the physician.</p>	1470	<p>The will be trained to administer medication in compliance with the physicians order.</p>	9/18/07
1484	<p>3822.11 MEDICATIONS</p> <p>Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to promptly destroy medication that had a missing label.</p>	1484	<p>Facility will destroy discard all prescribed medication that is discontinued by the physician or has reached the expiration date or has a worn, illegible or missing label.</p>	9/10/07

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(01) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

08Q176

(02) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(03) DATE SURVEY
COMPLETED

07/19/2007

NAME OF PROVIDER OR SUPPLIER

WHOLESTIC DS

STREET ADDRESS, CITY, STATE, ZIP CODE
7609 15TH STREET, NW
WASHINGTON, DC 20012

(04) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY)

(05)
CORRECTIVE
DATE

1454

Continued From page 12

The finding includes:

Observation of Resident #3's treatment kit on July 19, 2007 at 12:18 PM revealed a unlabeled tube of Ketuconazole 2% cream. Interview with the R.N. indicated the pharmacy applied the label to the bag containing the medication because the tube was too small for it. The RN further revealed that the client's initials were written on the tube. The medication was not observed stored in the bag containing the label to provide specific instructions to staff on how the medication was to be used.

1454