

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

PRINTED: 11/19/2008  
FORM APPROVED  
OMB NO. 0938-0391

*Received  
12/8/08*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  08G158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2008
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NAME OF PROVIDER OR SUPPLIER

WHOLISTIC 08

STREET ADDRESS, CITY, STATE, ZIP CODE

8827 1ST STREET, NW  
WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS  This recertification survey was conducted from October 21, 2008, through October 22, 2008. The survey was initiated using the fundamental survey process. Six male clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample.  The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	W 000		
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 observations, interviews and record reviews, the governing body failed to exercise general policy and operating direction over the facility.  The finding includes:  1. The governing body failed to ensure that the direct care staff implemented the agency seatbelt policy for safety. [See W189]  2. The governing body failed to ensure that the direct care staff implemented its infection control policy. [See W455]	W 104	W 104.1 See W189.  W 104.2 See W455.	12/15/08  12/15/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

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

*Matt Jones*

TITLE

*Vice President*

(X6) DATE

*12/1/08*

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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NAME OF PROVIDER OR SUPPLIER

WHOLISTIC 05

STREET ADDRESS, CITY, STATE, ZIP CODE

6627 1ST STREET, NW  
WASHINGTON, DC 20012

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W 153

Continued From page 1

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 interview and record review, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator or to other officials in accordance with State Law as required by DC regulation (22 DCMR Chapter 35 Section 3519.10), for two out of the three clients in the sample. (Clients #1 and #2)

The findings include:

Review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on October 21, 2008 at 1:45 PM, revealed the facility failed to report timely injuries of unknown origin as required;

1. On September 1, 2008, a direct care staff reported hearing a noise coming from Client #2's bedroom which was located on the second floor of the facility. According to the report, the staff went to the client's bedroom and discovered Client #2 sustained an injury to the head and face. Client #2 was taken to the emergency room for evaluation and treatment.

2. An unusual incident report dated July 9, 2008, revealed that Client #1 was observed by his one

W 153

W 153, 1&amp;2

According to tag W153, "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."

The afore-mentioned incidents were reported to Wholistic's administration in a timely manner.

In the future, the facility shall ensure that the Department of Health, HRA is informed of such incidents according to State law.

Staff will be trained by the Department on Disability Services (DDS) on incident management and procedures.

The Qualified Mental Retardation Professional (QMRP) will work collaboratively with

Wholistic's incident management coordinator to ensure compliance with State law.

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W 153	Continued From page 2 on one staff disrobing in the living room. According to the incident report, the direct care staff went to get a robe to cover the client. While the staff was assisting the Client #1 with putting on his robe, the staff discovered an abrasion on his right hand and elbow of unknown origin.	W 153			
W 169	Note: It should be noted that these injuries of unknown origin were not reported to the governmental agency until October 17, 2008. <b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b>  Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159	<b>W 159</b> <b>See W189.</b>  <b>12/15/08</b>		
W 189	This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen.  The finding includes:  The QMRP failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently. [See W159] <b>483.430(e)(1) STAFF TRAINING PROGRAM</b>  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.	W 189			

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W 189	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently.</p> <p>The findings include:</p> <p>1. Observation on October 21, 2008 at approximately 8:25 AM revealed the direct care staff assisting each client onto the van to leave for their respective day programs. Further observation revealed that Client #5 was the last client to board the van. After which the staff placed the step stool onto the van and closed the van's sliding door. The driver entered the van and pulled off.</p> <p>At no time prior to the van departing from the facility were staff observed to buckle each clients seatbelt in accordance with the agency safety policy.</p> <p>2. The facility's direct care staff failed to consistently implement the gaitbelt support for Client #5 as evidenced below:</p> <p>On October 21, 2008 at approximately 8:22 AM, a direct care staff was observed to take Client #5 to his bedroom holding him by his arm. While walking with Client #5 he began to lean forward. Further observation revealed that the client was wearing a black belt around his waist. At no time was the staff observed to use the belt as a support during the client's ambulation to his bedroom.</p>	W 189	<p><b>W 189.1</b></p> <p><b>Staff have been strongly advised to assist the clients with buckling their seatbelts at all times whenever they are seated in the van. The House Manager will on a weekly basis (five days a week) conduct spot checks to ensure compliance.</b></p> <p style="text-align: right;"><b>12/01/08</b></p>	

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W 189	Continued From page 4  Observation at approximately 4:30 PM, revealed the staff using the black belt around Client #5's waist to assist him to and from bathroom with much difficulty. Further observation revealed that the staff was not clear on how to use the black belt as a support for the client due to the staff member appearing to be unable to balance the client's weight while walking.  Interview with the House manager and the Qualified Mental Retardation Professional (QMRP) revealed that the black belt around the client's waist was a recommended gaitbelt which should be used to assist the staff to maintain the client's balance during ambulation.	W 189	<b>W 189.2</b> <b>The Physical Therapist (PT) will train staff on how to effectively use the gaitbelt when assisting client # 5 during ambulation.</b>  <b>12/15/08</b>	
W 217	On October 22, 2008 at approximately 2:30 PM, a review of the September 18, 2008 Human Right Committee minutes revealed that the Team approved Client #5's use of the gait belt for balance and to prevent falls during ambulation. <b>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</b>  The comprehensive functional assessment must include nutritional status.  This STANDARD is not met as evidenced by: Based on the observation, interview and record reviews, the facility failed to ensure that interventions put in place had been fully evaluated to ensure the effectiveness of a feeding protocol for one of six client residing in the facility. (Client #5)  The finding include:  The facility failed to ensure that the Professional	W 217		

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W 217	<p>Continued From page 5</p> <p>Staff (Nutrition, Speech) had assessed, monitored, and addressed Client #2's consumption of foods and head positioning to reduce client spillage. There was no evidence that the current mealtime interventions had been reevaluated and revisions considered as deemed warranted to ensure safe eating as evidenced by the following:</p> <p>Observation on October 21, 2008 at approximately 8:02 AM revealed Client #5 eating with his hands throughout his meal. At no time during breakfast did the morning staff redirect Client #5 while eating.</p> <p>On October 21, 2008 at approximately 8:17 PM, Client #5 was again observed eating with his fingers. After five minutes had passed, Client #5's assigned staff began to provide hand over hand assistance to the client while seated on the client's right side.</p> <p>Throughout the entire meal, Client #5's head was observed leaning to his right onto his shoulders. The staff providing hand over hand assistance was unable to see the client's mouth and appeared to have some difficulty providing this level of assistance while being seated. Approximately 40% of Client #5's food spilled on the dining room floor and in his lap.</p> <p>Interview with the nurse and the QMRP revealed that the client had a feeding protocol. Further interview with the nurse revealed that Client #5 had been sick and some of his feeding skills had decreased. Additionally, the nurse mentioned that his head positioning was the result of some deterioration of the muscles and it had been challenging at mealtimes.</p>	W 217	<p>W 217 Client #5's mealtime protocol will be revised to account for proper head position during feeding. Staff will be in-serviced on how to assist client #5 during feeding.</p> <p style="text-align: right;">12/20/08</p>	

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W 217	Continued From page 6	W 217		
W 455	<p>Review of the meal time protocol on the same evening at approximately 7:00 PM, revealed that Client #5 was "Independent with close supervision to insure adequate and safe dietary intake given visual deficits". Further review of the mealtime protocol made no mention of the proper head positioning to benefit and aid in the client's safe food consumption.</p> <p><b>483.470(l)(1) INFECTION CONTROL</b></p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to implement infectious control procedures to prevent communicable infectious diseases.</p> <p>The finding includes:</p> <p>On October 21, 2008 at approximately 5:55 PM, Client #1 was taken to the bathroom to wash his hands. At approximately 5:58 PM while sitting at the dining room table, Client #1 put his hands in his mouth several times. The staff responded, "Don't put your hands in your mouth. You just washed your hands."</p> <p>At approximately 6:15 PM staff placed Client #5's plate of food on the dining room table and he began to eat. Client #5 was not observed to return to the bathroom to wash his hands prior to receiving his meal.</p>	W 455	<p><b>W 455</b></p> <p>This should not be a concern because client #5 did not touch a foreign material/object. Instead, he put his hand in his own mouth which is the primary source of food intake. Had it been a case of client touched his nose or fecal area, infection control would have been a concern.</p>	
W9999	FINAL OBSERVATIONS	W9999		

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W9999	<p>Continued From page 7</p> <p>The following observations were made during the survey process. It is recommended that this areas be reviewed and determinations be made regarding appropriate action to prevent potential non-compliant practices:</p> <p>1. On October 21, 2008 at approximately 7:20 PM, observation revealed the Trained Medication Employee (TME) was pouring Client #2's evening medications. The Speech and Language consultant was observed to opened the door and enter the kitchen. Further observations revealed that the Speech consultant went directly to the counter where the TME was pouring the medications, reached over the TME and opened the cabinet.</p> <p>The Speech consultant commented "I am looking for a box low fat crackers." At no time prior to reaching over the TME did the Speech consultant acknowledge the TME pouring the medication or acknowledge Client #2 sitting in a chair directly next to the counter. There was no indication that the client's privacy was maintained during the medication administration.</p> <p>Immediately after the incident approximately 7:26 PM, interview with the nurse on duty revealed that the staff and the agency contract consultant have been trained not enter the kitchen while the client's are receiving their medications.</p> <p>2. Observation on October 21, 2008 at approximately 8:25 AM, revealed the direct care staff pulled a metal step stool with a support arm from the van. Further observation revealed the the step stool did not have rubber support stopper on its leg. Additionally, the steps surface was slick (no non slip surface noted). Additionally, the</p>	W9999	<p><b>W 9999.1</b></p> <p><b>This observation has been noted. The TME has been in-serviced to preserve clients' privacy during medication administration.</b></p> <p><b>Additionally, the QMRP, RN, and House Manager will monitor medication pass to ensure privacy.</b></p> <p style="text-align: right;">12/15/08</p>	

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W9999	Continued From page 8 metal arm support did not have a grip support for the clients to hold as they enter or exited the van.  Interview with the staff and the house manager acknowledged that the step stool was old and needed to be replaced to ensure safe loading and unloading of the clients.	W9999	W 9999.2 The step stool has been replaced.  12/15/08		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC DS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6627 1ST STREET, NW WASHINGTON, DC 20012</b>
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1 000	<p><b>INITIAL COMMENTS</b></p> <p>This licensure survey was conducted from October 21, 2008, through October 22, 2008. Six male clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.</p>	1 000		
1 022	<p><b>3501.6 ENVIRONMENTAL REQ / USE OF SPACE</b></p> <p>Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.</p> <p>This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure blinds and curtains at each window.</p> <p>The finding includes:</p> <p>An environmental walk-through was conducted on October 22 2008 at approximately 1:50 PM that revealed the blinds located in Resident #1's front window were torn.</p>	1 022	<p><b>1 022</b></p> <p>The blinds were replaced on the day of the survey.</p> <p><b>10/21/08</b></p>	
1 090	<p><b>3504.1 HOUSEKEEPING</b></p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p>	1 090		

Health Regulation Administration

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

*M. J. [Signature]*

TITLE  
*Vice President*

(X6) DATE

*12/2/08*

STATE FORM

9600

HPRQ11

If continuation sheet 1 of 4

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I 090	Continued From page 1  This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that the residence was maintained in a safe, clean, attractive and sanitary manner and free from an accumulation of dirt.  The findings include:  Internal  1. The ceiling fan in Resident #1's bedroom was observed to hit the wall when circulating.  2. The closet door outside of the office area was off track and broken.  3. The first floor bathroom had an accumulation of dust on the heating vent over the mirror.  4. The handle on the refrigerator door was loose and missing a screw.  5. The floor tile in front of the stove was loose and could pose a trip hazard.  6. The first floor bathroom support rail near the toilet had a sharpen edge of the metal support plate.  7. The freezer on the back porch was unable to close securely due to an accumulation of ice.	I 090	I 090.1 The ceiling fan will be repaired. 12/15/08  I 090.2 The closet door has been aligned. 10/25/08  I 090.3 The heating vent was cleaned on the day of the survey. 10/22/08  I 090.4 The refrigerator handle was repaired on the day of the survey. 10/22/08  I 090.5 The floor tile was replaced on the day of the survey. 10/22/08  I 090.6 The sharp edge object was replaced. 10/25/08  I 090.7 The freezer has been repaired and now closes well. 10/25/08	
I 206	3609.6 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	I 206	I 090. 1, 2, 3, 4, 5, 6, 7. Wholistic Services V, Inc. will be conducting monthly environmental audits to ensure compliance.	

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NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC 05</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8827 1ST STREET, NW WASHINGTON, DC 20012</b>		
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I 206	Continued From page 2  would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings.  The findings include:  Interview and review of the personnel records on October 2, 2008 revealed the GHMRP failed to provide evidence of physical examinations for the house manager, one QMRP, and two counselors (Staff #1 and #3)	I 206	<b>I 206</b> A current physical certificate for the QMRP was in the personnel records at the time of the survey. The House Manager and staff #1 have completed their physicals. Staff #3 has quit the job. <b>11/30/08</b>		
I 222	<b>3510.3 STAFF TRAINING</b>  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel.  The finding includes:  1. Observation on October 21, 2008 at approximately 8:25 AM revealed the direct care staff assisting each resident onto the van to leave for their respective day programs. Further observation revealed that Resident #5 was the last resident to board the van. After which the staff placed the step stool onto the van and closed the van's sliding door. The driver entered	I 222			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2008
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 05	STREET ADDRESS, CITY, STATE, ZIP CODE 6027 1ST 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) COMPLETE DATE
1 222	<p>Continued From page 3</p> <p>the van and pulled off.</p> <p>At no time prior to the van departing from the facility were staff observed to buckle each clients seatbelt in accordance with the agency safety policy.</p> <p>2. The facility's direct care staff failed to consistently implement the gaitbelt support for Resident #5 as evidenced below:</p> <p>On October 21, 2008 at approximately 8:22 AM, a direct care staff was observed to take Resident #5 to his bedroom holding him by his arm. While walking with Resident #5 he began to lean forward. Further observation revealed that the resident was wearing a black belt around his waist. At no time was the staff observed to use the belt as a support during the client's ambulation to his bedroom.</p> <p>Observation at approximately 4:30 PM, revealed the staff using the black belt around Resident #5's waist to assist him to and from bathroom with much difficulty. Further observation revealed that the staff was not clear on how to use the black belt as a support for the resident due to the staff member appearing to be unable to balance the client's weight while walking.</p> <p>Interview with the House manager and the Qualified Mental Retardation Professional (QMRP) revealed that the black belt around the client's waist was a recommended gaitbelt which should be used to assist the staff to maintain the client's balance during ambulation.</p> <p>On October 22, 2008 at approximately 2:30 PM, a review of the September 18, 2008 Human Right Committee minutes revealed that the Team</p>	1 222	<p>1 222.1</p> <p>Cross reference W189.1</p> <p>12/01/08</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2008
NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 05		STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 222	Continued From page 4 approved Resident #5's use of the gait belt for balance and to prevent falls during ambulation.  (See also Federal Deficiency Report Citation W189)	1 222	1 222.2 Cross reference W189.2 12/15/08	
1 226	3510.5(c) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (c) Infection control for staff and residents;  This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the implementation of infection control procedures to prevent communicable infectious diseases for one of three residents included in the sample. (Resident #1)  The finding includes:  On October 21, 2008 at approximately 5:55 PM, Resident #1 was taken to the bathroom to wash his hands. At approximately 5:58 PM while sitting at the dining room table, Resident #1 put his hands in his mouth several times. The staff responded, "Don't put your hands in your mouth. You just washed your hands."  At approximately 6:15 PM staff placed Resident #5's plate of food on the dining room table and he began to eat. Resident #5 was not observed to return to the bathroom to wash his hands prior to receiving his meal.  (See also Federal Deficiency Citation W455)	1 226		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC 05</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8627 1ST STREET, NW WASHINGTON, DC 20012</b>
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1 227	Continued From page 5	1 227		
1 227	<p><b>3510.5(d) STAFF TRAINING</b></p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of training in first aid, Cardiopulmonary Resuscitation (CPR) as required.</p> <p>The finding includes:</p> <p>On May 3, 2006, review of personnel records/training records revealed that three counselors (Staff #1 - #3) hired to work at the facility did not have current training in First Aid and CPR.</p>	1 227	<p><b>1 227</b> Staff #1 has submitted copies of his certification in CPR and First Aid. <u>11/01/08</u></p> <p>Staff #3 has resigned from Wholistic Services Inc. <u>10/30/08</u></p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/22/2008
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC 05	STREET ADDRESS, CITY, STATE, ZIP CODE 6627 1ST STREET, NW WASHINGTON, DC 20012
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R 000	INITIAL COMMENTS  This licensure survey was conducted from October 21, 2008, through October 22, 2008. Six male clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample.  The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT  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.  This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any 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.  The findings include:  Review of the personnel records on 9/5/08 at 1:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for one direct	R 125		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michelle Hoover* TITLE: *Vice President* DATE: *11/1/08*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/22/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC 05</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8627 1ST STREET, NW WASHINGTON, DC 20012</b>		
(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
R 125	Continued From page 1 care staff (#1), the driver and the Qualified Mental Retardation Professional.	R 125	<p><b>R 125</b> Staff #1 and the driver have signed consent forms to conduct criminal background checks.</p> <p>The QMRP's background check was in the personnel folder at the time of the survey. Please find attached a copy. <b>11/07/07</b></p>	