PRINTED: 11/27/2007
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G185	A. BUILDING _____ B. WING _____	11/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 04	1314 PERRY STREET, NE WASHINGTON, DC 20017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from November 19, 2007 thru November 21, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of two males and three females with various disabilities. The findings of the survey were based on observations in the home, interviews with staff in the home, one guardian, one family member, and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is 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. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, 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 one of three clients included in the sample. (Client #1) The finding includes: a. Observation of the evening medication administration on 11/19/07 at 7:07 PM, revealed	W 124		

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 DEC -7 P 2:14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mattie Thomas
TITLE: Vice President & Clinical Director
(X6) DATE: 12/7/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 Client #1 received Geodon 40 mg by mouth. Interview with the nursing staff on the same day at approximately 7:10 PM revealed that the medications were prescribed for behavior management. Review of the client's physicians orders dated November 2007 on 11/20/07 at approximately 2:37 PM revealed that medications were incorporated in a Behavior Support Plan (BSP) dated 9/10/07, to address behaviors associated with self-injurious skin picking and palm biting, poking herself, feces smearing, trichotillomania (pulling hair from scalp), excessive scratching, and skin picking. Client #1 also receives 1:1 staffing 24 hours a day. Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 at approximately 1:00 PM revealed that Client #1 did not have a legal guardian. Review of Client #1's Psychological Assessment dated 7/21/07 on 11/21/07 at approximately 9:38 AM indicated that the client did not evidence the capacity to make independent decisions regarding her habilitation planning, placement, treatment, financial, or medial 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 her 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. b. Review of Client #1's medical records on 11/20/07 at approximately 2:37 PM revealed a medical consult dated 4/11/07. According to the consult, consent was obtained when Client #1 had a colonoscopy procedure performed on 4/11/07. Interview with the QMRP 11/21/07 at	W 124	Wholistic has informed the DDS Case Manager about client #1's need for a gaurdian. Healthcare agent is in place however, this process is not legally recognized by DOH	on-going

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W 124	Continued From page 2 approximately 1:30 PM revealed that Client #1's sister was involved in her medical care. Further interview revealed that Client #1's sister was not his legal guardian or her surrogate decision maker. Review of Client #1's Psychological Assessment dated 7/21/07 on 11/21/07 at approximately 9:38 AM indicated that the client did not evidence the capacity to make independent decisions regarding her habilitation planning, placement, treatment, financial, or medial matters. There was no documented evidence that the facility informed Client #1 as appropriate, of the health benefits and risks of treatment associated with the colonoscopy. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate each client's active treatment. The findings include: 1. The facility's QMRP failed to ensure that staff demonstrated competency in implementing Client #1's intervention strategies in the Behavior Support Plan (BSP). [See W193]	W 159	See W193	

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W 159	Continued From page 3	W 159		
	2. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team was furnished for Client #2. [See W436]		See W436	
	3. The facility's QMRP failed to ensure the 1:1 staff person for Client #1 provided consistent staff coverage in accordance with the Individual Support Plan (ISP) for Client #1. [See W186]		See W186	
	4. The facility's QMRP failed to ensure staff demonstrated competency in the implementation of Client #1's Behavior Support Plan (BSP). [See W193]		See W193	
	5. The facility's QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately. [See W252]		See W252	
	6. The facility's QMRP failed to ensure that clients received interventions as specified in their Behavior Support Plan (BSP). [See W249]		See W249	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		
	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.			
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently.			

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W 189	Continued From page 4 The findings include: 1. The facility failed to ensure that newly hired staff demonstrated competency in the implementation of Client #1 Behavior Support Plan (BSP). [See W193] 2. The facility failed to ensure that staff had received effective training on documenting Client #1's targeted behaviors on the Antecedent Behavior Consequence (ABC) Data Collection Sheets. [See W252.1] 3. The facility failed to ensure that staff had received effective training on documenting Client #1's targeted behaviors on the Antecedent Behavior Consequence (ABC) Data Collection Sheets. [See W252.2]	W 189	See W193 See W252.1 See W252.2	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in the implementation of Client #1's Behavior Support Plan (BSP). The finding includes: Observations conducted on 11/19/07 from 3:42 PM to 3:46 PM revealed Client #1 sitting in the living room area picking/scratching at her right middle finger while the client's 1:1 staff was in another room in the facility. Interview with Client #1's 1:1 staff person on 11/19/07 at	W 193		

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W 193	Continued From page 5 approximately 10:53 AM revealed that part of her duties of a 1:1 required her to provide eye sight supervision at all times. The 1:1 staff person further revealed that when she needed to use the restroom, another staff person not engaged with other clients in the facility, was required to watch the client. Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 at 2:00 PM revealed Client #1 received 1:1 staffing 24 hours a day due to severe aggressive behaviors and to make certain the client did not injure herself, or others. Further interview with the QMRP revealed that she had made the same observations of Client #1 picking/scratching her middle finger without intervention from the 1:1 staff. Review of the Client #1's September 2007 Behavior Support Plan (BSP) on 11/21/07 at approximately 9:38 PM revealed that the clients target behaviors included: self-injurious skin picking and palm biting, poking herself, feces smearing, trichotillomania (pulling hair from scalp), and excessive scratching. The BSP detailed the duties/responsibilities of the 1:1 staff person. According to the duties, the staff person and the client should consistently maintain physical proximity with each other at all times. At the time of the survey, the facility failed to ensure that the 1:1 staff remained in close proximity with Client #1 according to the duties of the 1:1 stated in the BSP.	W 193	1.1 has been retrained on their duties. QMRP & House Manager shall ensure that 1:1 adhere to job duties and remain proximate to client #1.	12/7/07
W 248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal	W 248		

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W 248	Continued From page 6 guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each client's Individual Support Plan (ISP) was available to all relevant staff and/or outside agencies, for one of three clients included in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #3's day program was provided with the current ISP as evidenced below: Interview with the day program Case Manager (CM) on 11/20/07 at 9:40 AM revealed that the day program did not have a current copy of the Client #3's current Individual Support Plan (ISP). The CM stated that "we wish we could received the ISP's sooner." The CM further stated that it's really difficult to get the ISP's to the day program in a timely manner. Review of the day programs current ISP revealed that the plan had expired on 5/15/06. Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 at approximately 12:55 PM revealed that the Department on Disability Services (DDS) was responsible for ensuring Client #3's ISP was sent to the day program. Review of Client #3's records in the home revealed a current ISP dated 6/4/07.	W 248	Only certified DDS copies of the ISP are acceptable to Day programs. DOS is solely responsible for providing ISP's to Day Programs.	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 7 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that clients received interventions as specified in their Behavior Support Plan (BSP) for one of three clients included in the sample. (Clients #1) The finding includes: Observations conducted on 11/19/07 from 3:42 PM to 3:46 PM revealed Client #1 sitting in the living room area picking/scratching at her right middle finger off/on while the 1:1 staff person was in another room in the facility. The 1:1 staff person was not observed to redirect the behavior when returning from the other room in the facility. Review of Client #1's BSP dated 9/10/07 reviewed on 11/21/07 at approximately 9:38 PM revealed "Intervention Strategies" to decrease the maladaptive behaviors of skin picking/excessive scratching. According to the intervention strategies, staff should tell Client #1 to stop the behavior. Continue making the request in a calm manner while gently guiding her hands to her lap. Client #1's 1:1 staff was not observed to implement intervention strategies to address the skin picking/excessive scratching as outlined in the BSP. Interview with the Qualified Mental	W 249	1:1 staff has been retrained on duties and the improtance of adhering to the proximity requirement.	12/7/07

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W 249	Continued From page 8 Retardation Professional (QMRP) on 11/21/07 at approximately 2:00 PM revealed that she had made the same observations of Client #1 skin picking/scratching her middle finger without intervention from the 1:1 staff. There was no evidence that Client #1's 1:1 staff person implemented intervention strategies to decrease maladaptive behaviors of skin picking/excessive scratching strategies in accordance to the BSP.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for two of three clients in the sample.(Client #1 and #2) The findings include: 1. Observations conducted on 11/19/07 from 3:42 PM to 3:46 PM revealed Client #1 sitting in the living room area picking/scratching at her right middle finger off/on while the 1:1 staff person was in another room in the facility. The 1:1 staff person was not observed to redirect the behavior when returning from the other room in the facility. Review of Client #1 Behavior Support Plan (BSP) dated 9/10/07 on 11/21/07 at approximately 9:38 PM revealed that staff was to record target behaviors on the Antecedent Behavior	W 252	Staff will be trained on ABC documentation and IPP documentation on 12/17/07	12/7/07

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W 252	Continued From page 9 Consequence (ABC) charts. On 11/21/07 at approximately 10:56 AM the review of the ABC data collection sheets did not reflect Client #1 skin picking/excessive scratching observed on 11/19/07. There was no evidence that the data had been collected in accordance with the BSP for Client #1, which was necessary for a functional assessment of the client's progress. 2. The facility failed to ensure that data had been collected in accordance with the IPPs for Client #2, which was necessary for a functional assessment of the client's progress as evidenced below: Evening observations conducted on 11/119/07 at approximately 5:20 PM PM revealed Client #2 sitting at the dining table with peers and staff. The client was observed identify peers sitting at the table by names. Review of the client's Individual Program Plan (IPP) dated 9/12/07 revealed a program objective which read "given model demonstration, the client will identify two of his house mates when their names are called 100% trials per month." Further review of the data collection revealed no documentation data for 10/30/07 and 11/20/07. Client #2 had another IPP objective which read "the client will distinguish between a dollar and a quarter given verbal prompts 100% of trials recorded." Review of the data collection revealed no documentation data for 10/31/07. Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 at approximately 2:10 PM acknowledged the lack of documentation for for those days.	W 252		
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE	W 261		

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W 261	Continued From page 10 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: Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 and review of the HRC meetings minutes at approximately 10:42 AM revealed a discussion and approval for Client #1's updated Behavior Support Plan to include psychotropic medications and Bilateral hand mittens. Further review of the HRC minutes revealed that the committee had discussed and approved the clients diet. Review of the corresponding signature sheet attached to the minutes, however, failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility.	W 261	Facility has a community representative, James Crawford, however he was unable to attend that particular meeting. James Crawford has participated in other meetings.	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE 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.	W 263		

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W 263	Continued From page 11 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 one of three clients included in the sample. (Client #1) The finding includes: The facility's human rights committee failed to ensure that informed consent had been obtained for the use of Client #1's Behavior Support Plan (BSP) in conjunction with the use of prescribed psychotropic medications as evidenced below. [See W124]	W 263	Client 1 is in need of a guardian. Upon assignment of a guardian BSP will be submitted for informed consent.	on-going
W 356	483.460(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 with the nurse and record review, the facility failed to ensure comprehensive dental treatment services that include dental care needed maintenance of dental health had been provided for one of three clients include in the sample (#1). The finding includes: Review of Client #1's medical records on	W 356		

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W 356	Continued From page 12 11/20/07 at approximately 3:15 AM revealed a dental consult dated 11/20/06. According to the consult, the dentist recommended that "the client needs scaling, and indicated she "will submit pre-authorization to Medicaid for approval." Further review of the medical records revealed another dental consult dated 3/28/07. The recall exam revealed moderate calculus deposits. The dentist recommended client the needs scaling, and indicated she "will submit pre-authorization to Medicaid for approval." Interview with the facility's Registered Nurse (RN) on 11/21/07 at approximately 1:35 PM confirmed that the client had not received recommended dental at the time of the survey. The RN indicated that if dental services are not rendered on Client #1's next scheduled dental appointment in December 2007, the facility will start the process over again to obtain authorization for dental services.	W 356	Client #1's appointment has been scheduled (in fact, prior to survey) and executed accordingly. If appointment not executed consult will specifically state reason.	12/21/07
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of one clients who requires glucose testing. (Client #1 and #2) The findings include: 1. Interview with the Licensed Practical Nurse (LPN) on 11/19/07 at approximately 1:00 PM, revealed that Client #1 had a diagnosis of pre-diabetes Type II and was prescribed Glucophage	W 393	Wholistic will follow-up with DOH to ascertain a certificate waiver for 493 of the chapter.	

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W 393	Continued From page 13 500 mg one tab by mouth twice a day. Further interview with the LPN revealed that blood glucose measurements, utilizing a glucometer, were to be taken two times weekly. Interview with the Registered Nurse (RN) on the same day at approximately 2:00 PM revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA). Review of the Medication Administration Record (MAR) on 11/19/07 at approximately 7:45 PM revealed that Client#2 was prescribed finger sticks to monitor his glucose levels two times weekly [Note: The facility was referred to the Department of Health (DOH)laboratory surveyor for an application review on 11/19/07 at 3:00 P.M.] 2. Interview with the Licensed Practical Nurse (LPN) on 11/19/07 at approximately 1:00 PM, revealed that Client #2 had a diagnosis of Diabetes Mellitus, Type II and was prescribed Glucophage 850 mg one tab twice a day. Further interview with the LPN revealed that blood glucose measurements, utilizing a glucometer, were to be taken before breakfast and dinner. Interview with the Registered Nurse (RN) on the same day at approximately 2:00 PM revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA). Review of the Client #2's Medication Administration Record (MAR) on 11/19/07 at approximately 7:45 PM revealed that Client#2 is prescribed finger sticks to monitor his glucose levels daily.	W 393		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed	W 436		

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W 436	Continued From page 14 choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that clients were provided with necessary adaptive equipment for one of three clients included in the sample. (Client #2) The finding includes: Observations of the lunch meal conducted on 11/19/07 at approximately 1:59 PM revealed Client #2 was served a turkey sandwich with vegetable soup, peers pureed in a sectional divided plate on a Dycem mat and low fat milk and water as his beverage. Further observations revealed the assigned Licensed Practical Nurse (LPN) assisting the client with holding the long handed teaspoon while trying to serve himself. The client was showing some unsteadiness with bringing the teaspoon from the plate to his mouth. Interview with LPN revealed that Client #2 was encouraged to feed himself as much as possible independently or until he becomes fatigue. Review of Client #2's Occupational Therapist (OT) Assessment dated 9/27/07 on 11/21/07 at approximately 8:37 AM revealed a recommended the "usage of a spoon with built up a handle to increase independence in manipulating utensils. Interview with the facility's Registered Nurse (RN) and Qualified Mental Retardation Professional (QMRP) on the same day at approximately PM	W 436		

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	09G185		11/21/2007

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W 436	Continued From page 15 acknowledges that the client had not received the recommended adaptive equipment. Further interview with the QMRP and RN revealed that the adaptive spoon had been ordered. At the time of the survey, there was no evidence built up spoon had been purchased for Client #2 as recommended by the OT.	W 436	Built up spoon has been ordered. Spoon should arrive by 15th of December	12/15/07
W 441	483.470(i)(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 11/19/07 at approximately 12:30 PM revealed that the fire drills were conducted via the front/back, basement, and side door. Observations of the medication pass at approximately 6:12 PM revealed an fire exit in Clients #2 and #5 bedroom. Interview with the House Manager at approximately 6:20 PM revealed that the fire exit in Clients #2 and #5 should be used as an escape exit during fire drills. There was no evidence that evacuation drills were held under varied conditions.	W 441	The regulations require varied conditions/exits, not all exits. Clearly various exits were utilized. The findings do not support the conclusion that the standard had not been met.	12/7/07

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R 000	INITIAL COMMENTS A licensure survey was conducted from November 19, 2007 thru November 21, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of two males and three females with various disabilities. The findings of the survey were based on observations in the home, interviews with staff in the home, one guardian, one family member, and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	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 for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for one of staff. The finding includes: Review of the review of personnel files on November 21, 2007 PM revealed the GHMRP failed provide evidence of a criminal background checks for the previous seven years in all jurisdiction where one direct care staff had worked or resided. (Staff #1, #2, #3, #4, #5, #6,	R 125	Please find attached a copy of Police clearance for all employees.	12/7/07

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Martha [signature] TITLE Vice President & Clinical Director (X6) DATE 12/7/07

STATE FORM 5699 MFJ011 If continuation sheet 1 of 2

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R 125	Continued From page 1 #7, #8, #9, HM, LPN #1, LPN #2, LPN#3, LPN #4, and RN).	R 125		

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I 000	INITIAL COMMENTS A licensure survey was conducted from November 19, 2007 thru November 21, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of two males and three females with various disabilities. The findings of the survey were based on observations in the home, interviews with staff in the home, one guardian, one family member, and at two day programs, as well as a review of client and administrative records, including incident/investigation reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. On November 21, 2007 an environment inspection was conducted and revealed the following deficiencies: 1. Handrails leading to the basement located on the right side of the wall as you going down was observed to have be loose. There were screws detached from the wall that's connected to the handrails.	I 090	Handrails have been fixed.	12/7/07

Health Regulation Administration
Matt Thomas
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Vice President of Clinical Director

(X6) DATE 12/7/07

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I 090	Continued From page 1	I 090		
	2. There no curtains observed in the bathroom located on the first level.		Curtains have been put in first level bath.	12/7/07
	3. The windown was detached from the base located down stairs in the basement over the washing/dryer machines.		Basement window will be re-attached.	12/15/07
	4. Cobb webbs noted as you exit from the basement down.		Cobb webs have been cleared.	12/7/07
I 135	3505.5 FIRE SAFETY	I 135		
	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.		These findings do not speak to the regulation.	
	The finding includes:			
	Review of the facility's fire drill records on 11/19/07 at approximately 12:30 PM revealed that the fire drills were conducted via the front/back, basement, and side door. Observations of the medication pass at approximately 6:12 PM revealed an fire exit in Residents #2 and #5 bedroom. Interview with the House Manager at approximately 6:20 PM revealed that the fire exit in Residents #2 and #5 should be used as an escape exit during fire drills. There was no evidence that evacuation drills were held under varied conditions.			
I 203	3509.3 PERSONNEL POLICIES	I 203		

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I 203	Continued From page 2 Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute Is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: 1. Review of the personnel files conducted on 11/21/07 revealed the GHMRP failed to provide evidence of current signed job descriptions fourt of ten (S #2, #5, #9 had no date, and the HM)	I 203	All employees now have current signed job descriptions	12/7/07
I 206	3509.6 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 would allow him or her to perform the required duties. 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 11/21/07 revealed no documented evidence of current health certificates for direct care staff. [S #6 and C#7 and #8]	I 206	Health certificates for all Direct Care STaff ar all in place.	12/7/07

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I 222	Continued From page 3	I 222		
I 222	3510.3 STAFF TRAINING	I 222		
	There shall be continuous, ongoing in-service training programs scheduled for all personnel.			
	This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently.			
	The findings include:			
	1. The facility failed to ensure that newly hired staff demonstrated competency in the implementation of Client #1 Behavior Support Plan (BSP). [See W193]		See W193	
	2. The facility failed to ensure that staff had received effective training on documenting Client #1's targeted behaviors on the Antecedent Behavior Consequence (ABC) Data Collection Sheets. [See W252.1]		See W252.1	
	3. The facility failed to ensure that staff had received effective training on documenting Client #1's targeted behaviors on the Antecedent Behavior Consequence (ABC) Data Collection Sheets. [See W252.2]		See W252.2	
I 379	3519.10 EMERGENCIES	I 379		
	In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living			

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I 379	Continued From page 4 arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on record review the facility failed to report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. Review of the facility's unusual incident reports on 11/19/07 at approximately 11:05 AM revealed and incident dated 7/1/07. According the the incident, Client #5 was sent to the Providence ER for vomiting two times, coffee brown and had black tarry stool. There was no documented evidence that this incident had been reported to governmental agencies as required. 2. An incident dated 4/23/07 revealed Client #4's GI tube was worn out and needed to be evaluated and possibly replaced by the GI doctor. A leak was noted from the tube. The client was admitted to the hospital for GI tube replacement. There was no documented evidence that this incident had been reported to governmental agencies as required. 3. On 2/11/07, Client #2 was lethargic, drowsy with minimal sweating. The emergency personnel 911 was called and transported the client to the hospital in which he was admitted. There was no documented evidence that this	I 379	Wholistic shall notify HRA of all unusual incidents within 24 hours or the next business day.	12/7/07

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I 379	Continued From page 5 incident had been reported to governmental agencies as required.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview with the nurse and record review, the GHRMP failed to ensure comprehensive dental treatment services that include dental care needed maintenance of dental health had been provided for one of three residents include in the sample (Resident#1). The finding includes: Review of Resident #1's medical records on 11/20/07 at approximately 3:15 AM revealed a dental consult dated 11/20/06. According to the consult, the dentist recommended that "the client needs scaling, and indicated she "will submit pre-authorization to Medicaid for approval." Further review of the medical records revealed another dental consult dated 3/28/07. The recall exam revealed moderate calculus deposits. The dentist recommended client the needs scaling, and indicated she "will submit pre-authorization to Medicaid for approval." Interview with the facility's Registered Nurse (RN) on 11/21/07 at approximately 1:35 PM confirmed that the client had not received recommended dental at the time of the survey. The RN indicated that if dental services are not rendered on Resident #1's next	I 401	See W356	

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I 401	Continued From page 6	I 401		
	scheduled dental appointment in December 2007, the facility will start the process over again to obtain authorization for dental services.			
I 420	3521.1 HABILITATION AND TRAINING	I 420		
	Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.			
	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate each client's active treatment.			
	The findings include:			
	1. The facility's QMRP failed to ensure that staff demonstrated competency in implementing Client #1's intervention strategies in the Behavior Support Plan (BSP). [See W193]		See W193	
	2. The facility's QMRP failed to ensure that adaptive equipment identified as needed by the interdisciplinary team was furnished for Client #2. [See W436]		See W436	
	3. The facility's QMRP failed to ensure the 1:1 staff person for Client #1 provided consistent staff coverage in accordance with the Individual Support Plan (ISP) for Client #1. [See W186]		See W186	
	4. The facility's QMRP failed to ensure staff demonstrated competency in the implementation of Client #1's Behavior Support Plan (BSP). [See			

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I 420	Continued From page 7	I 420		
	W193]		See W193	
	5. The facility's QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately. [See W252]		See W252	
	6. The facility's QMRP failed to ensure that clients received interventions as specified in their Behavior Support Plan (BSP). [See W249]		See W249	
I 422	3521.3 HABILITATION AND TRAINING	I 422		
	Each GHMRP 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 observation, staff interview and record review the GHMRP failed to ensure that clients received interventions as specified in their Behavior Support Plan (BSP) for one of three clients included in the sample. (Clients #1)		1:1 staff have bee trained on client #1's BSP	12/7/07
	The finding includes:			
	Observations conducted on 11/19/07 from 3:42 PM to 3:46 PM revealed Client #1 sitting in the living room area picking/scratching at her right middle finger off/on while the 1:1 staff person was in another room in the facility. The 1:1 staff person was not observed to redirect the behavior when returning from the other room in the facility. Review of Client #1's BSP dated 9/10/07 reviewed on 11/21/07 at approximately 9:38 PM revealed "Intervention Strategies" to decrease the maladaptive behaviors of skin picking/excessive scratching. According to the intervention strategies, staff should tell Client #1 to stop the behavior. Continue making the request in a calm			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G185	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 8 manner while gently guiding her hands to her lap. Client #1's 1:1 staff was not observed to implement intervention strategies to address the skin picking/excessive scratching as outlined in the BSP. Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 at approximately 2:00 PM revealed that she had made the same observations of Client #1 skin picking/scratching her middle finger without intervention from the 1:1 staff. There was no evidence that Client #1's 1:1 staff person implemented intervention strategies to decrease maladaptive behaviors of skin picking/excessive scratching strategies in accordance to the BSP.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record verification, 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 one of three clients included in the sample. (Client #1) The finding includes: 1a. Observation of the evening medication administration on 11/19/07 at 7:07 PM, revealed Client #1 received Geodon 40 mg by mouth. Interview with the nursing staff on the same day	I 500	See W124	on-going

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017		

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I 500	Continued From page 9 at approximately 7:10 PM revealed that the medications were prescribed for behavior management. Review of the client's physicians orders dated November 2007 on 11/20/07 at approximately 2:37 PM revealed that medications were incorporated in a Behavior Support Plan (BSP) dated 9/10/07, to address behaviors associated with self-injurious skin picking and palm biting, poking herself, feces smearing, trichotillomania (pulling hair from scalp), excessive scratching, and skin picking. Client #1 also receives 1:1 staffing 24 hours a day . Interview with the Qualified Mental Retardation Professional (QMRP) on 11/21/07 at approximately 1:00 PM revealed that Client #1 did not have a legal guardian. Further interview with the QMRP revealed that Client #3's sister was involved and signed consents for her medical procedures. Review of Client #1's Psychological Assessment dated 7/21/07 on 11/21/07 at approximately 9:38 AM indicated that the client does not evidence the capacity to make independent decisions regarding her habilitation planning, placement, treatment, financial, or medial 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 her 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. b. Review of Client #1's medical records on 11/20/07 at approximately 2:37 PM revealed a medical consult dated 4/11/07. According to the consult, consent was obtained when Client #1 had a colonoscopy procedure performed on 4/11/07. Interview with the QMRP 11/21/07 at	I 500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G185	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017		

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I 500	Continued From page 10 approximately 1:30 PM revealed that Client #1's sister is involved in her medical care. Further interview revealed that Client #1's sister is not his legal guardian or her surrogate decision maker. Review of Client #1's Psychological Assessment dated 7/21/07 on 11/21/07 at approximately 9:38 AM indicated that the client does not evidence the capacity to make independent decisions regarding her habilitation planning, placement, treatment, financial, or medial matters. There was no documented evidence that the facility informed Client #1 as appropriate, of the health benefits and risks of treatment associated with the colonoscopy. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	I 500		

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To: Sheila Pannell **FROM:** Miatta Thomas

Fax: 202-442-9430 **Date:** 12/7/2007

Phone:

Re: POC Perry Street **CC:**

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