PRINTED: 05/04/2007
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: 09C160	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/13/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC DT		STREET ADDRESS, CITY, STATE, ZIP CODE 78 53RD PLACE, SE WASHINGTON, DC 20019	

(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 April 11 through April 13, 2007. The survey was initiated using the fundamental survey process; however, it was determined that an extended process should be implemented under the condition level of participation of active treatment. A random sample of three clients was selected from a residential population of six males. Two clients in the sample had diagnoses of profound mental retardation and the third client was diagnosed with severe mental retardation. All of the clients in the facility had psychiatric diagnoses for which medications were prescribed. One random selected client had one to one staffing as part of the behavioral support plan. The consumers in this facility had limited to no skills in verbal communications. 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. As a result of the survey findings it was determined that the facility was not in compliance at the Condition Level of Participation under Active Treatment.	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for	W 100		

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ADMINISTRATION
2007 MAY 24 A 11:16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitta Thomas | TITLE: Vice President | (X6) DATE: 5/23/07

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 100	Continued From page 1 mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.	W 100		
	This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Condition of Participation in Active Treatment as detailed below: The findings include: The facility failed to ensure that client (s) were provided continuous learning opportunities to enhance and/or maintain their present skills. (Refer to W249)		W 100 Please refer to W 196 W 247 W 248 W 195	
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 observation, interviews with the Qualified Mental Retardation Professional (QMRP) and review of behavioral support plan (s) (BSP), the facility failed to demonstrate how the rights of all clients were protected and failed to	W 125		

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W 125	Continued From page 2 allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States for 5 of 6 clients in the sample. The findings include: 1. During the survey conducted April 11-13, 2007, there was a bell alarm that rang each time one of the exit doors was opened. On April 13, 2007, the Qualified Mental Retardation Professional and the Registered Nurse were interviewed at 1:00 PM about the purpose of the bell/alarm. The QMRP and the RN stated that client #1 had a history of absconding. Both the QMRP and the RN, indicated that the client had not recently demonstrated this behavior at the facility but had at the day program. The RN stated that the use of the alarm had been approved by the Human Rights Committee (HRC). This was also verified thru review of the January 9, 2007 HRC meeting minutes. The RN was also interviewed regarding how other clients felt about the alarm and how the facility facilitated getting input from them. The facility staff did not provide surveyor with any evidencethat other clients were considered prior to the installation of the bell alarm. According to the QMRP and the RN, the facility made the decision due to the need toensure Client #1's safety. At 12:30 PM, client #1's behavioral support plan (BSP) was reviewed to determine if elopement or absconding were included as targeted behaviors and neither were included. On January 9, 2007, the facility's Human Rights Committee (HRC) approved the use of the door alarm as indicated in the meeting. It could not be determined that there were mechanisms in place	W 125	W125 Client #1 HRC re-convened and decided to D/C the use of the buzzer and locking up of sharps due to fact that there hasn't been any documented incidents of elopement/attempted elopement, SIB and physical aggression using sharp objects. In addition, HRC format has incorporated an area that discusses potential impact on residents.	05/21/07

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W 125	Continued From page 3 to ascertain clients' opinion and responses to changes in their environment that could violate clients' rights. 2. During interview with the QMRP and the RN on April 13, 2007, at 11:45 AM, an inquiry was made as to why on the evening of April 11, 2007, during the dinner meal, none of the clients were provided with forks and knives. The RN indicated that knives are locked up for the protection of clients. It was explained by the RN that client #1 had aggressive behaviors which was verified through a review of his BSP. However, the BSP did not contain any indication that knives or other harmful items had been used by client #1. The facility denied all clients the right to learn and to use forks and knives. There were no documented contraindications relevant to utensils. There was no evidence that the clients of the facility or a legally sanctioned entity were involved in the decision making that denied the clients rights to use knives and/or folks.	W 125		
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on interview with the the Qualified Mental Retardation Professional (QMRP) and review of individual program plan (IPP) the facility failed to	W 126		

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W 125	Continued From page 4 ensure that clients [#1] received challenging opportunities to enhance the clients financial management skills. The findings include: According to client #1's IPP, the client did not have a financial goal to assist him with learning to manage his funds. The QMRP stated during the interview on April 13, 2007, at 11:30 AM, that a financial objective had not been established for client #1 although there was a financial assessment available. The assessment did reflect areas of need.	W 126	W126 Money management program has been drafted and will be presented to client #1 IDT team for approval and implementation. Given physical assistance, [redacted] will identify monetary value 100 % of recorded trials per month.	06/01/07
W 136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on the review of recreational documents and interview with the Qualified Mental Retardation Professional (QMRP), the facility failed to promote individual and small group community outings. The findings include: On April 13, 2007, at 11:00 AM, clients #1, #2, and #3's community outing logs were reviewed for the months of January 2007 through April 2007. The log identified that these clients consistently attend the same community outings together. The QMRP was interviewed on April 13, 2007 at 10:45 AM, confirmed that the clients in the facility	W 136	W132 QMRP and House manager ensures that community activities are frequent and appropriate. Logistics impact our ability to take clients out in small groups or by themselves (with staff). They include staffing & transportation policy of 2 staff in the vehicle as long as 1 consumer is in the van. However, Provider will divide	

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W 196	Continued From page 5 do regularly attend the same community outings. It could not be determined that clients were encouraged to participate in individualized or small groupings of three or less on a continuous basis.	W 196	outings into smaller outings	05/21/07
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on the review of incident reports, interview with the Qualified Mental Retardation Professional, and review of the facility's policy, the facility failed to implement policies that ensured the continuous protection of residents in the facility. The findings include: According to the facility's incident policy, "Incidents of unknown origin should be reported and investigated". Incident reports were reviewed on April 11, 2007 at 11:10 AM. The following incident reports were reviewed and no investigations were provided during the survey. a. August 1, 2006 - client #5 was discovered to have a scratch on his face. b. August 19, 2006 - client #3 was reportedly discovered to have black discoloration on his left lower eye lid. c. April 15, 2006 - a bruise was discovered on	W 149	W149 QMRP monthly notes will be revised that will include a section for IR, if any occurred and if so whether an investigation is necessary and has been submitted.	05/21/07

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W 149	Continued From page 5 client #3's left arm after arriving from his day program. In these instances, it could not be determined that the facility had ensured the implementation of their policy for injuries of unknown origin.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on the review of incident reports, interview with the Qualified Mental Retardation Professional, and review of the facility's policy, the facility failed to investigate clients' injuries that were discovered for two of six clients in the facility. The findings include: According to the facility's incident policy, "Incidents of unknown origin should be reported and investigated". Incident reports were reviewed on April 11, 2007 at 11:10 AM. The following incident reports were reviewed and no investigations were provided during the survey. a. August 1, 2006 - client #5 was discovered to have a scratch on his face. b. August 19, 2006 - client #3 was reportedly discovered to have black discoloration on his left lower eye lid. c. April 18, 2006 - reportedly, a bruise was discovered on client #3's left arm after arriving	W 154	W154 Please refer to W149	05/21/07

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W 154	Continued From page 7 from his day program. In these instances, it could not be determined that the facility had ensured the implementation of their policy to investigate injuries of unknown origin.	W 154		
W 159	483.430(e) 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 observations, interviews, and review of clinical records, the Qualified Mental Retardation Professional (QMRP) demonstrated a lack of integration and coordination of active treatment programs for two of three clients in the sample (#2 and #3). The findings include: 1. The QMRP failed to ensure that clients [#1] received challenging opportunities to enhance the clients financial management skills. [Refer to W126]	W 159	→ Please refer to W126	
	2. The QMRP failed to ensure that the facility failed to promote individual and small group community outings. [Refer to W136]	→	Please refer to W136	
	3. The QMRP failed to ensure that clients (#1 and #2) were provided the opportunities for making choices as part of their self-management. [Refer to W247]	→	Please refer to W247	
	4. The QMRP failed to ensure that programs	→	Please refer to W278	

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W 159	Continued From page 8 using restrictive measures followed the use of lesser restrictive measures. [Refer to 279].	W 159		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, direct care staff interviews, interview with the Qualified Mental Retardation Professional, and record review, the facility failed to provide active treatment for those who did need it. [Refer to W196] The cumulative effect of these systemic practices results in the failure of the facility to deliver statutorily mandated active treatment to its clients.	W 195	W195 Please refer to W196	05/23/07
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that clients #1	W 196		

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W 196	Continued From page 9 and #2 were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). The findings include: 1. The facility failed to provide continuous opportunities for active treatment for client #1. a. During observation conducted on April 11, 2007, between 4:40 PM to 8:00 PM, client #1's activities included the following: 4:15 PM - The client had a snack and returned to seat in living room; 4:55 PM - The client put on his shoes and coat after being directed by staff. Along with one of the client's peers, the client left the facility to accompany staff on an errand; 5:05 PM - The client returned to the facility; 6:15 PM - The client was observed eating dinner. Client was observed to cut his meat using a spoon and then used his finger to push the food onto the spoon. There was no staff intervention; 7:00 PM - After the nurse prepared the client's medications, the client took his medications with supervision; 7:50 PM - The client was requested to "get the games out" by the staff. The client independently completed the puzzle (shapes and daily used objects); 8:00 PM - The client went to the restroom and returned to the same puzzle that he completed	W 196	W196 QMRP will conduct an in-service with staff on 05/19/07 about the importance of active treatments and the implementation of the daily activity schedule. This training will emphasize on engaging the clients in meaningful exercise/activities. Also, QMRP will ensure that staff take opportunity of training (Active Treatment) offered by DDS and Georgetown. QMRP will also observe staff between 4pm - 8 pm and document any concerns in the staff communication book.	05/19/07

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W 198	Continued From page 10 and dismantled several times. During this time, the staff was observed to asked the client to touch the texture board. The client complied and there were no further instructions given. b. Client #1's activity schedule reflected the following scheduled activities for the evening: 5:00 PM - The client will be encouraged to assist with preparing the appetizer. The client will be engaged in recreation and leisure activities while dinner is prepared. 5:45 PM - The client will wash his hands. The client will set the table. 6:00 PM - The client will eat dinner. 8:45 PM - The client will be encouraged to clean up dining room area using house chore chart. 7:15 PM - The client will identify pictures in his communications book. The client will walk up and down stairs in the house. c. Client #1's individual program plan (IPP) included programs to prepare vegetables for dinner, to identify his housemates, and to exercises. The client was not offered the opportunities to engage in these programs at available opportunities. Based on the observation and record review, it could not be determined that opportunities for learning new skills or maintaining skills were offered. 2. On April 12, 2007, at 2:00 PM, client #1's individual program plan (IPP), dated July 2006	W 198	between 4pm - 8pm QMRP will observe to ensure that client #1 IPP and Activity schedule is adhere to and followed by staff. Any concern(s) will be documented in the staff communication book.	05/21/07

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W 196	Continued From page 11 was reviewed. The client had a program that read "Will identify pictures in his communication/picture book with 80% accuracy". Although the documentation for April 11, 2007 reflected that the program had been implemented and stated "he did good", there was no observation of a communications book during the four hours of observation. In addition, the QMRP and House Manager searched for the book to show the surveyor on April 13, 2007, at 11:25 AM. It could not be determined that the communications program was being implemented or that the booklet was available throughout client #1's day to encourage his communications skills.	W 196		
	3. According to client #1's IPP, the client did not have a financial goal to assist him with learning to manage his funds.	→	See W126	
	4. The facility failed to integrate varying activities in client #2's daily activities to provide varied and continuous opportunities for learning and participating for client #2.			
	a. During the observation conducted on April 11, 2007 from 4:15 PM to 8: 00 PM, client #2 was involved in the following activities: retrieved his bowls from the kitchen during snack and dinner with verbal prompting; went on a ride to another facility with staff to pick up items; received medications; and held an instrument awaiting staff involvement but never played the instrument. The staff realized that batteries were needed for the instrument.	→	QMRP has provided an electrical adapter for the keyboard and will do periodical inspection to ensure that the instrument is in working order.	04/16/07
	b. Client #2's activity schedule reflected that the client was scheduled to participated in setting the table, however the staff performed this task without client assistance. The client was also	→	QMRP will revice client # 2 Activity schedule to reflect the days his house chores should be performed.	05/18/07

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W 196	Continued From page 12 scheduled to participate in recreation/leisure activity; to participate in restoring eating area; and to participate in music activity for 10 minutes.	W 196		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients (#1 and #2) were provided the opportunities for making choices as part of their self-management. The finding includes: During observation at the facility conducted on April 11, 2007, clients #1 and #2 were not encouraged to identify their preferences or to communicate their choices. No choices were offered during observation from 4:00 PM to 8:15 PM. [Refer to W249].	W 247	W 247 QMRP will conduct an in-service on 05/19/07 on clients choices and rights. Staff were re-trained on informal programming. Choices are now being offered and QMRP will observe and document any concerns in the staff communication book.	05/19/07
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional	W 278		

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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 A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	093160		04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	75 53RD PLACE, S.E. WASHINGTON, DC 20019

(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 278	Continued From page 13 (QMRP) and the Registered Nurse (RN) and review of client #1's individual support plan (ISP), the facility failed to ensure the implementation of restrictive measures. Additionally, the facility failed to ensure that clients records documented that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective for all clients in the facility. The findings include: 1. During the survey conducted April 11-13, 2007, there was a bell alarm, that rang each time that one of the exit doors were opened. On April 13, 2007, at 1:00 PM, the Qualified Mental Retardation Professional and the Registered Nurse were interviewed about the purpose for the bell. The QMRP and the RN stated that client #1 had a history of elopement. They indicated that the client had not recently demonstrated this behavior at the facility but had at the day program. The RN stated that the use of the alarm had been approved by the Human Rights Committee (HRC). The RN was further interviewed regarding how other clients felt about the alarm and how the facility facilitated getting the others opinion about the alarms. There was no clear definitive responses to reflect that other clients had been considered prior to the installation of the bell alarm. According to the QMRP and the RN, the facility made the determination based on the safety need for client #1. At 1:40 PM, client #1's behavioral support plan (BSP) was reviewed for the targeted behaviors. Client #1's BSP did not reflect a targeted behavior for elopement and did not reference elopement behaviors.	W 278	W278 Please refer to W125 The format of the new HRC form will incorporate the discussion of lesser intrusive techniques.	05/23/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G180	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2007
NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 07		STREET ADDRESS, CITY, STATE, ZIP CODE: 75 53RD PLACE, SE WASHINGTON, DC 20019	

(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 278	Continued From page 14 There was no evidence that elopement behavior for client #1 had been addressed through any other mechanism including the BSP. The Human Rights Committee (HRC) approved the use of the door alarm as documented by the committee minutes dated April 2, 2007. There was no evidence to justify the use of the door alarm or a clear determination about the possible restrictive impact the alarm proposed on all clients in the facility. 2. Interviews with the QMRP and the RN on April 13, 2007, at 11:45 AM was conducted to ascertain why on the evening of April 11, 2007, during the dinner meal, none of the clients were provided with forks and knives. The RN indicated that knives were locked up for the protection of clients. The RN explained that client #1 had aggressive behaviors. Review of the BSP for client #1 was done on April 13, 2007 and aggression was identified as a targeted behavior. There was no indication in the BSP that knives or other harmful items had been used by client #1. There was no evidence that programs incorporating the use of lesser intrusive or more positive techniques had been considered for the clients in this facility.	W 278	→ Please refer to W128	
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	W 288		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G160		04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	79 53RD PLACE, SE WASHINGTON, DC 20019

(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 288	Continued From page 15 This STANDARD is not met as evidenced by: Based on interviews with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse (RN), review of psychological report and behavioral support plan (BSP) the facility failed to demonstrate that techniques used were not used in substitution of active treatment to manage stated inappropriate client behavior for client #1. The findings include: During the survey conducted April 11-13, 2007, there was a bell alarm that rang each time that one of the exit doors were opened. On April 13, 2007, the Qualified Mental Retardation Professional and the Registered Nurse were interviewed about the purpose for the bell. The QMRP and the RN stated that client #1 had a history of elopement. They indicated that the client had not recently demonstrated this behavior at the facility but had at the day program. The RN stated that the use of the alarm had been approved by the Human Rights Committee (HRC). According to the QMRP and the RN, the facility made the determination to use the door alarms based on the safety needs for client #1. At 12:30 PM, client #1's behavioral support plan (BSP) was reviewed for the targeted behaviors. Client #1's BSP did not reflect a targeted behavior for elopement and the BSP did not refer to elopement behaviors. It could not be determined that client #1's stated behavior had been addressed through implementation of active treatment program strategies.	W 288	W288 Please refer to W125 The new format will ensure that all restrictions are directly associated with the targeted behaviors and HRC will review all relevant information prior to approval.	05/24/07
W 319	483.450(a)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior	W 319		

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	090160		04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	78 53RD PLACE, SE WASHINGTON, DC 20019

(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 316	Continued From page 16 must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on observation, review of behavioral data and the psychological assessment for client #1, the facility failed to ensure that medications to support control of inappropriate behaviors had been gradually withdrawn in over a year. The finding includes: During the medication administration that was observed on April 11, 2007 at 6:00 PM, client #1 administered with supervision; Trazodone HCL, Trileptal, and Zyprexa. Client #1's physician's order for April 2007 reflected that the client had diagnoses of intermittent explosive disorder and obsessive compulsive disorder. The behavioral goal read: "If there are zero incidents of targeted behaviors for six months, consider decreasing the psychotropic medications". Although client #1 had not met the zero criterion of all behaviors, there had been a decrease in the target behaviors from March 2006 to March 2007 as detailed below: physical aggression (5 incidents), property destruction (5 incidents), absconding (2 incidents); food binging (2 incidents). There was no evidence that a gradual withdrawal had been considered atleast annually.	W 316	W 316 client #1 did not meet the goal of zero incidents in 6 months and continues to display his targeted behaviors at his day program. However, Psychiatric annual assessment will consider gradual withdrawal.	05/23/07
W 386	483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse	W 386		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 090160	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 07		STREET ADDRESS, CITY, STATE, ZIP CODE 78 53RD PLACE, N.E. WASHINGTON, DC 20019	

(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 386	Continued From page 17 Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308). This STANDARD is not met as evidenced by: Based on interview with the Trained Medication Administration Employee (TME) and the Registered Nurse (RN), the facility failed to ensure that the facility reconciled the receipt and disposition of a level IV controlled substance for one on six clients in the facility. The finding includes: On April 11, 2007, the TME was observed administering and instructing clients in administration of their medications at 8:00 PM. A locked box was stored in the medication closet. The staff retrieved Phenobarbital from this box. The Phenobarbital was administered by the TME to client #5. The TME was questioned about the record keeping of controlled substances. The TME admitted that she did not maintain a reconciliation document.	W 386	A reconciliation document has been placed in the MAR. TME's will be trained on the use of the reconciliation form.	05/23/07
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 the review of fire drill records the facility failed to ensure that clients in the facility had been trained and supported to evacuate the facility during general sleep hours. The finding includes:	W 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G160		04/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	75 53RD PLACE, S.E. WASHINGTON, D.C. 20019

(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 441	Continued From page 18 The facility's fire drill log of documented drills dated from December 2006 to April 2007was reviewed on April 11, 2007 at 2:35 PM. There was no evidence that during this period that the facility complied with training and assisting clients during all shifts. There were no documented drills during periods when clients were likely asleep during the night/early morning.	W 441	W441 House manager will implement Fire drill Schedule to include when clients are asleep. Facility will conduct fire drill on sleeping hours on 05/23/07. QMRP will review fire drills monthly to ensure varied hours.	05/23/07

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	000160		04/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	75 53RD PLACE, SE WASHINGTON, DC 20019

(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 000	INITIAL COMMENTS This licensure survey was conducted from April 11 through April 13, 2007. A random sample of three clients was selected from a residential population of six males. Two clients in the sample had diagnoses of profound mental retardation and the third client was diagnosed with severe mental retardation. All of the clients in the facility had psychiatric diagnoses for which medications were prescribed. One client randomly who was randomly selected had one to one staffing as part of the behavioral support plan. The consumers in this facility had limited to no skills in verbal communications. The findings of this survey were 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.	I 000		
I 135	3505.5 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: The findings includes: Refer to deficiency report W441.	I 135	I 135 Please refer to W441	05/23/07
I 160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and	I 160		

Health Regulation Administration

Marta Thomas — LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Vice President — (X6) DATE: 5/23/07

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/12/2007
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 07	STREET ADDRESS, CITY, STATE, ZIP CODE 79 53RD PLACE, SE WASHINGTON, DC 20019		

(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 160	Continued From page 1 provide guidance to each staff member. This Statute is not met as evidenced by: The findings includes: Refer to deficiency report W149 and W154.	I 160	I 160 Please refer	
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: The findings includes: Refer to deficiency report W196.	I 420	I 420 Please refer to W196	
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: The findings includes: Refer to deficiency report W125.	I 430	I 430 Please refer to W125	
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the	I 437		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G160	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/12/2007
NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 07	STREET ADDRESS, CITY, STATE, ZIP CODE: 78 53RD PLACE, SE WASHINGTON, DC 20019		

(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 437	Continued From page 2 GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: The findings includes: Refer to deficiency report W196.	I 437	I 437 Please refer to W196.	
I 443	3521.7(m) HABILITATION AND TRAINING The Habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (m) Financial management (including budgeting and banking); This Statute is not met as evidenced by: The findings includes: Refer to deficiency report W126.	I 443	I 443 Please refer to W126	
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.	I 500		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G150	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/12/2007
NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 07	STREET ADDRESS, CITY, STATE, ZIP CODE: 79 53RD PLACE, SE WASHINGTON, DC 20019		

(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 500	Continued From page 3 This Statute is not met as evidenced by: The findings includes: Refer to deficiency report W125 and W247:	I 500	I 500 Please refer to W125 and W247	