PRINTED: 10/01/2008
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
	09G148	A. BUILDING _____ B. WING _____	C 08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1614 BUNKER HILL ROAD, 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 On August 4, 2008, the State Agency (SA) was notified via telephone by the Qualified Mental Retardation Professional (QMRP) of the death of Client #1. According to the telephone interview with the QMRP, Client #1 was transported to Providence Hospital Emergency Department on July 11, 2008 because of a leaky gastric tube and subsequently admitted for treatment of an infection in the stomach area. On July 25, 2008, Client #1 was discharged from Providence Hospital to Hadley Specialty Hospital for further treatment of an infection in the stomach area. On August 2, 2008, Client #1 was transported from Hadley Specialty Hospital to United Medical Hospital Emergency Department with a diagnosis of hypotension. Client #1 was pronounced dead at United Medical Hospital on August 2, 2008, at approximately 9:37 PM. An on-site investigation was conducted by the SA on August 28, 2008, to verify compliance with federal regulatory requirements prior to Client #1's death. The results of the investigation were based on interviews with the facility's nursing and direct care staff and administrative personnel. Also the findings were based on the review of the client's habilitation, medical, and administrative records; including incident reports.	W 000	Received 10/15/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Miatta Thomas
TITLE: Vice President
(X6) DATE: 10/14/08

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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	09G148		C 08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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W 153	Continued From page 1 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to District of Columbia Regulations (22 DCMR, Chapter 35, Section 3519.10) one of one client in the investigation. (Client #1) The finding includes: Review of the physician's order sheet (POS) dated April 29 - July 30, 2008, on September 2, 2008 at approximately 4:40 PM revealed that Client #1 had diagnoses that included immune thrombocytopenia and purpura. Review of a nursing progress note dated June 21, 2008, on September 2, 2008 at approximately 4:40 PM revealed that Client #1 was discovered to have sustained discoloration and slight swelling on the left ankle measuring 2 x 3 centimeters of unknown origin. Review of a nursing quarterly dated July 10, 2008, on September 2, 2008 at approximately 5:00 PM revealed that the area was treated from June 21-25, 2008, with cold compresses in addition to elevating the left ankle. There was no documented evidence that this incident had been reported to the administrator or governmental agencies as required.	W 153	Provider has instituted new protocols for reporting unusual incidents. This change was implemented in September 2008 pursuant to a survey at our 7533 12th Street facility. Protocols include but are not limited to faxing all reports to the main office, an office Administrator call HRA to ensure receipt and documentation of wholistic conversation with HRA.	9/15/08
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.	W 159		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1914 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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W 159	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for one of one client in the investigation. (Client #1) The finding includes: Cross Refer to W331.1 The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that the gastroenterologist's recommendation for weight reduction was addressed for Client # 1 in a timely manner.	W 159	See W 331.1	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services, for one of the one client in the investigation. (Client # 1) The finding includes: Cross refer to W331.1. The facility's nursing staff failed to inform the Primary Care Physician (PCP) or nutritionist of the gastroenterologist recommendations in a timely manner.	W 322	See W 331.1	
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the	W 325		

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W 325	Continued From page 3 physician. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of one client in the investigation. (Client #1) The finding includes: Review of a laboratory study for Client #1 dated November 30, 2007, on August 8, 2008, at approximately 1:50 PM revealed an order for the client to have a repeat SMA 12 laboratory test performed. Review of Client #1's laboratory studies on September 22, 2008, at approximately 2:10 PM revealed that the SMA 12 laboratory test was not performed until January 7, 2008. There was no evidence that the SMA 12 laboratory test was scheduled or obtained as recommended by the physician in a timely manner.	W 325	RN will ensure recommendations are followed in timely manner. However, in this circumstance, SMA 12 Lab's should be proximate to visit (Dr.'s visit) to be most optimal. Moving forward any delay shall be documented in the record to ensure that monitors / surveyors are aware of the factors that contribute to outcomes that may appear (at least anecdotally) "poorly managed.	9/15/08
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs for one of one client in the investigation. (Client #1) The findings include: 1. Review of Client #1's, gastroenterologist (GI)	W 331		

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	09G148		C 09/29/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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W 331	Continued From page 4 consult dated June 17, 2008, on September 25, 2008, at approximately 3:00 PM revealed a recommendation for weight reduction secondary to increased abdominal girth. Additionally, the consult documented the client's recent weight gain which would cause an increase in the risk of aspiration. Review of Client #1's, monthly nursing assessment dated June, 2008, on September 25, 2008, at approximately 3:30 PM revealed that the Registered Nurse (RN) would discuss the gastroenterologist's recommendations with the nutritionist. Additionally, the monthly nursing assessment documented the client's weight as 88.5 pounds [Ideal Body Weight 70-94 pounds]. Interview with the Licensed Practical Nurse (LPN) on October 1, 2008, at approximately 2:35 PM revealed that in July, 2008, Client #1 weighed 90.1 pounds. Review of Client #1's, nutritional assessment dated July 11, 2008, (24 days after the GI consult) on September 25, 2008, at approximately 3:50 PM, reflected Client #1's gastroenterologist recommendation for weight reduction. The nutritionist recommended discontinuing Client #1's Nutren 1.5 at continuous infusion rate of 65 ml. per hour for 12 hours to provide 1170 k calories and 46 grams protein per day. Further review revealed a recommendation that Client #1 be provided Nutren 1.5 at a continuous infusion rate of 50 ml. per hour for 12 hours to provide 900 k calories and 35 grams protein per day. In addition, Prosource, 2 ounces per day to provide 20 grams of protein per day, was also recommended. Review of Client #1's, medical consult dated June, 2008, on September 25, 2008 at approximately 4:14 PM revealed a recommendation to continue the current treatment plan. Review of Client #1's, physician's orders dated July 11, 2008, on September 25,	W 331	Client #1 was within Ideal Body weight parameters throughout the time in question. The team convene and changes were made within 30 days. We believe this is timely. In the future, RN will communicate recommendation immediately and document her efforts in the record.	9/15/08

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NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 03

STREET ADDRESS, CITY, STATE, ZIP CODE: 1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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W 331	Continued From page 5 2008 at approximately 4:24 PM reflected Client #1's nutritionist recommendations for weight reduction, twenty-four days after the gastroenterologist's recommendation. Review of Client #1's Medication Administration Records (MAR's) dated July 11, 2008 on September 19, 2008 at approximately 4:30 PM revealed that Nutren 1.5 at a continuous infusion rate of 65 ml. per hour for 12 hours providing 1170 k calories and 46 grams protein per day was discontinued. Further review revealed that on July 11, 2008, Nutren 1.5 at a continuous infusion rate of 50 ml. per hour for 12 hours providing 900 k calories and 35 grams protein per day and Prosource, 2 ounces per day providing 20 grams of protein per day was transcribed. There was no documented evidence that the facility's nursing staff informed the Primary Care Physician (PCP) or nutritionist of the gastroenterologist recommendations in a timely manner. 2. The facility's nursing services failed to obtain the results of Client # 1's pap smear as evidenced by: Review of a Gyn consult dated April 1, 2008 on September 22, 2008, at approximately 12:10 PM revealed that Client #1 had a pap smear performed on April 1, 2008. There was no documented evidence that Client #1's pap smear results had been obtained by the facility. 3. The facility's nursing staff failed to update Client #1's Health Management Care Plan (HMCP) as evidenced by: Interview with the Licensed Practical Nurse (LPN) on August 28, 2008 at approximately 9:25 AM revealed that Client #1's gastric tube was flushed	W 331	Request on two separate occasions were made for Client's #1 pap smear results. In the future, RN shall document in the record all effort to ascertain results and document in Nursing Monthly Notes.	9/15/08

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W 331	Continued From page 6 with 200ccs of water four times a day. Review of the physician's orders dated April 29 - July 30, 2008, on September 19, 2008, at approximately 11:55 AM revealed an order to flush the gastric tube with 200ccs of water four times daily. Review of Client #1's Medication Administration Records (MAR's) dated April 1-July 10, 2008 on September 19, 2008, at approximately 11:40 AM revealed that the documentation on the Mar's indicated that Client #1's gastric tube was flushed with 200ccs four times a day. Review of the first quarter nutritional assessment dated April 21, 2008 on September 19, 2008 at approximately 12:15 PM revealed that the client should be provided with 200 ccs of free water four times a day. Review of Client #1's Health Management Care Plan (HMCP) dated July 11, 2008 on September 19, 2008 at approximately 12:40 PM revealed that the HMCP indicated that Client #1's gastric tube should be flushed with 200ccs three times a day. There was no documented evidence that the HMCP was updated to include providing Client #1 with 200 ccs of water four times a day. 4. The facility's nursing staff failed to update Client #1's HMCP as evidenced by: Review of Client #1's HMCP dated July 11, 2008 on September 19, 2008 at approximately 12:40 PM revealed that the HMCP indicated "notify nurse if no bowel movement for 48 hours (2 days)". Review of the physician's orders dated July 30, 2008, on September 19, 2008 at approximately 12:55 PM revealed an order to call the medical doctor "if no bowel movement in 20 hours or exhibited signs and symptoms of impaction". There was no documented evidence that the HMCP was updated to include notifying the medical doctor if Client #1 had no bowel	W 331	Client #1 HMCP has been updated to include that PCP will be notified if no bowel movement in 20 hours or detection of impaction. Client #1 is deceased. But RN shall ensure that HMCP's	9/15/08

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NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 03

STREET ADDRESS, CITY, STATE, ZIP CODE: 1314 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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W 331	Continued From page 7 movement in 20 hours or exhibited signs and symptoms of impaction.	W 331	are accurate and appropriate and timely updated.	9/15/08
	5. The facility's nursing services failed to schedule Client # 1's annual ENT appointment as recommended by the Primary Care Physician (PCP) as evidenced by:			
	Interview with the LPN on August 28, 2008 at approximately 9:45 AM revealed that Client #1 had not been scheduled for an ENT. Review of an ENT consult dated May 7, 2007 on September 26, 2008, at approximately 1:10 PM revealed that Client #1 was recommended to return for a follow-up appointment in one year. Review of a physical examination dated January 11, 2008 on September 26, 2008, at approximately 1:10 PM revealed that Client #1 was recommended to have an ENT examination every year. Review of the physician's orders dated April 29 - July 30, 2008, on September There was no documented evidence that Client #1's ENT appointment had been scheduled or obtained by the facility.		ENT Appointments have been challenging to obtain. However, RN will document all efforts to ascertain medical appointments in records moving forward.	9/15/08
	6. Cross Refer to W153. The facility's nursing staff failed to immediately report to the administrator that Client #1 was discovered on June 21, 2008 to have sustained discoloration and slight swelling on the left ankle measuring 2 x 3 centimeters of unknown origin.		See W153	
	7. Cross refer to W325. The facility's nursing staff failed to provide routine laboratory testing as determined necessary by the physician for Client #1.		see W325	

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/28/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 03	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017		

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I 000	INITIAL COMMENTS On August 4, 2008, the State Agency (SA) was notified via telephone by the Qualified Mental Retardation Professional (QMRP) of the death of Resident #1. According to the telephone interview with the QMRP, Resident #1 was transported to Providence Hospital Emergency Department on July 11, 2008, because of a leaky gastric tube and subsequently admitted for treatment of an infection in the stomach area. On July 25, 2008, Resident #1 was discharged from Providence Hospital to Hadley Specialty Hospital for further treatment of an infection in the stomach area. On August 2, 2008, Resident #1 was transported from Hadley Specialty Hospital to United Medical Hospital Emergency Department with a diagnosis of hypotension. Resident #1 was pronounced dead at United Medical Hospital on August 2, 2008, at approximately 9:37 PM. An on-site investigation was conducted by the SA on August 28, 2008, to verify compliance with federal regulatory requirements prior to Resident #1's death. The results of the investigation were based on interviews with the facility's nursing and direct care staff and administrative personnel. Also the findings were based on the review of the client's habilitation, medical, administrative records; including incident reports.	I 000	Received 10/15/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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.	I 401		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mirta Thomas

TITLE: Vice President

(X6) DATE: 10/14/08

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Health Regulation Administration

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I 401	Continued From page 1 This Statute is not met as evidenced by: The GHMRP failed to provide professional services that included 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, for one resident in the investigation. (Resident #1) The findings include: 1. Review of Resident #1's, gastroenterologist consult dated June 17, 2008, on September 25, 2008 at approximately 3:00 PM revealed a recommendation for weight reduction secondary to increased abdominal girth. Additionally the consult documented the residents recent weight gain which would cause an increase in the risk of aspiration. Review of Resident #1's, monthly nursing assessment dated June, 2008, on September 25, 2008 at approximately 3:30 PM revealed that the Registered Nurse (RN) would discuss the gastroenterologist's recommendations with the nutritionist. Additionally, the monthly nursing assessment documented the resident's weight as 88.5 pounds [Ideal Body Weight 70-94 pounds]. Interview with the Licensed Practical Nurse (LPN) on October 1, 2008, at approximately 2:35 PM revealed that in July, 2008, Resident #1 weighed 90.1 pounds (weight gain of 1.6 pounds). Review of Resident #1's, nutritional assessment dated July 11, 2008, (24 days after the GI consult) on September 25, 2008 at approximately 3:50 PM, reflected Resident #1's gastroenterologist recommendation for weight reduction. The nutritionist recommended discontinuing Resident #1's Nutren 1.5 at continuous infusion rate of 65 ml. per hour for 12 hours to provide 1170 k calories	I 401	See W 331	

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I 401	Continued From page 2 and 46 grams protein per day. Further review revealed a recommendation that Resident #1 be provided Nutren 1.5 at a continuous Infusion rate of 50 ml. per hour for 12 hours to provide 900 k calories and 35 grams protein per day. In addition, Prosource, 2 ounces per day to provide 20 grams of protein per day, was also recommended. Review of Resident #1's, medical consult dated June, 2008, on September 25, 2008 at approximately 4:14 PM revealed a recommendation to continue the current treatment plan. Review of Resident #1's, physician's orders dated July 11, 2008, on September 25, 2008 at approximately 4:24 PM reflected Resident #1's nutritionist recommendations for weight reduction, twenty-four days after the gastroenterologist's recommendation. Review of Resident #1's Medication Administration Records (MAR's) dated July 11, 2008 on September 19, 2008 at approximately 4:30 PM revealed that Nutren 1.5 at a continuous Infusion rate of 65 ml. per hour for 12 hours providing 1170 k calories and 46 grams protein per day was discontinued. Further review revealed that on July 11, 2008, Nutren 1.5 at a continuous Infusion rate of 50 ml. per hour for 12 hours providing 900 k calories and 35 grams protein per day and Prosource, 2 ounces per day providing 20 grams of protein per day was transcribed. There was no documented evidence that the facility's nursing staff informed the Primary Care Physician (PCP) or nutritionist of the gastroenterologist recommendations in a timely manner. 2. The facility's nursing services failed to obtain the results of Resident # 1's pap smear as evidenced by: Review of a Gyn consult dated April 1, 2008 on	I 401		

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	HFD03-0070		C 09/28/2008

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WHOLISTIC 03	1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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I 401	Continued From page 3 September 22, 2008, at approximately 12:10 PM revealed that Resident #1 had a pap smear performed on April 1, 2008. There was no documented evidence that Resident #1's pap smear results had been obtained by the facility. 3. The facility's nursing staff failed to update Resident #1's Health Management Care Plan (HMCP) as evidenced by: Interview with the Licensed Practical Nurse (LPN) on August 28, 2008 at approximately 9:25 AM revealed that Resident #1's gastric tube was flushed with 200ccs of water four times a day. Review of the physician's orders dated April 29 - July 30, 2008, on September 19, 2008 at approximately 11:55 AM revealed an order to flush the gastric tube with 200ccs of water four times daily. Review of Resident #1's Medication Administration Records (MAR's) dated April 1-July 10, 2008 on September 19, 2008 at approximately 11:40 AM revealed that the documentation on the Mar's indicated that Resident #1's gastric tube was flushed with 200ccs four times a day. Review of the first quarter nutritional assessment dated April 21, 2008 on September 19, 2008 at approximately 12:15 PM revealed that the client should be provided with 200 ccs of free water four times a day. Review of Resident #1's Health Management Care Plan (HMCP) dated July 11, 2008 on September 19, 2008 at approximately 12:40 PM revealed that the HMCP indicated that Resident #1's gastric tube should be flushed with 200ccs three times a day. There was no documented evidence that the HMCP was updated to include providing Resident #1 with 200 ccs of water four times a day. 4. The facility's nursing staff failed to update	I 401	See W331 See W331	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/28/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 03	STREET ADDRESS, CITY, STATE, ZIP CODE 1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017		

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I 401	Continued From page 4 Resident #1's HMCP as evidenced by: Review of Resident #1's HMCP dated July 11, 2008 on September 19, 2008 at approximately 12:40 PM revealed that the HMCP indicated "notify nurse if no bowel movement for 48 hours (2 days)". Review of the physician's orders dated July 30, 2008, on September 19, 2008 at approximately 12:55 PM revealed an order to call the medical doctor "if no bowel movement in 20 hours or exhibited signs and symptoms of impaction". There was no documented evidence that the HMCP was updated to include notifying the medical doctor if Resident #1 had no bowel movement in 20 hours or exhibited signs and symptoms of impaction. 5. The facility's nursing services failed to schedule Resident # 1's annual ENT appointment as recommended by the PCP as evidenced by: Review of an ENT consult dated May 7, 2007 on September 26, 2008, at approximately 1:10 PM revealed that Resident #1 was recommended to return for a follow-up appointment in one year. Review of a physical examination dated January 11, 2008 on September 26, 2008, at approximately 1:10 PM revealed that Resident #1 was recommended to have an ENT examination every year. There was no documented evidence that Resident #1's ENT appointment had been scheduled or obtained by the facility. 6. The facility's nursing staff failed to immediately report to the Department of Health an event which substantially interfered with Resident #1's health as evidenced by: Review of the physician's order sheet (POS) dated April 29 - July 30, 2008, on September 2,	I 401	See W331	

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FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0070	A. BUILDING B. WING	C 08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 03	1814 BUNKER HILL ROAD, NE WASHINGTON, DC 20017

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I 401	Continued From page 5 2008 at approximately 4:40 PM revealed that Client #1 had diagnoses that included immune thrombocytopenia and purpura. Review of a nursing progress note dated June 21, 2008, on September 2, 2008 at approximately 4:40 PM revealed that Client #1 was discovered to have sustained discoloration and slight swelling on the left ankle measuring 2 x 3 centimeters of unknown origin. Review of a nursing quarterly dated July 10, 2008, on September 2, 2008 at approximately 5:00 PM revealed that the area was treated from June 21-25, 2008, with cold compresses in addition to elevating the left ankle. There was no documented evidence that this incident had been reported to the administrator or governmental agencies as required. 7. The facility's nursing staff failed to provide routine laboratory testing as determined necessary by the physician for Resident #1 as evidenced by: Review of a laboratory study revealed a physician's order for Resident #1 dated November 30, 2007, on August 8, 2008 at approximately 1:50 PM revealed an order for the client to have a repeat SMA 12 laboratory test performed. Review of Resident #1's laboratory studies on September 22, 2008, at approximately 2:10 PM revealed that the SMA 12 laboratory test was not performed until January 7, 2008. There was no evidence that the SMA 12 laboratory test was scheduled or obtained as recommended by the physician in a timely manner.	I 401	See W331	