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

PRINTED: 04/05/2007
FORM APPROVED
OMB NO. 0938-0391

| 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 ____ | 03/15/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHOLISTIC 03 | 1814 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 |
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| W 000 | INITIAL COMMENTS<br><br>A re-certification survey was conducted from 03/13/2007 through 03/14/2007. A random sampling of three clients was selected from a population of five individuals with varying degrees of disabilities.<br><br>This survey was initiated using the fundamental process; however, due to concerns in the areas of managing the reports of unusual incidents, staffing, and client ' s treatment programming the process was extended to review compliance in the Conditions of Participation (CoP) for Client Protection and Active Treatment. Further examination into this facility ' s lack of compliance with these CoPs resulted in a decision to conduct full survey to focus on the conditions of Governing Body and Management, and Facility Staffing.<br><br>The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports. | W 000 | | |
| W 122 | 483.420 CLIENT PROTECTIONS<br><br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by: Based on observation, staff interview and record review the facility failed to meet the conditions of participation in the area of client protections. The facility was found to be non-compliant as evidence by its failure to establish a system to inform clients and/or their advocates of the | W 122 | **W 122**<br>**A form is in place which will be used to inform clients of their rights as citizens of the United States and of the right to due process (Reference W125).**<br><br>**Staff have been in-serviced on privacy, dignity, and respect. The House Manager will, on a daily basis remind staff to adhere to the training guidelines (Reference W130).**<br><br>**A form has been developed to track, report, and investigate injuries of unknown origin. Staff have been in-serviced on incident reporting policies and procedures (Reference W153 & W154). Please see herewith supporting documents.**<br>**04/18/07** | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | [signature] | 4/19/07 |

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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| | 09G148 | | 03/15/2007 |

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 122 | Continued From page 1<br>attendant risks of treatment [W124]; the facility failed to inform clients of their rights as clients of the facility and as citizens of the United States and of the right to due process [Reference W126]; the facility failed to ensure client privacy [Reference W130]; and failed to ensure that incidents of injuries were reported and investigated timely [Reference W153 and W154]. These systemic failures were identified in how the facility managed care for four of six of the clients residing in the facility.<br><br>The effects of these systemic practices results in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being. | W 122 | | |
| W 124 | 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS<br><br>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.<br><br>This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure each client, parent, or legally authorized party of the attendant risks of treatment, behavioral status, and of the right to refuse treatment for the utilization of wrist bands, helmet, and psychotropic medication for two or three sampled clients. [Clients #1 and #2]<br><br>The findings include: | W 124 | **W 124 (1)**<br>**The system of informing clients, parent, legal guardian of the client's behavioral status, risks of treatment, and the right to refuse treatment is inherent in the Individual Support Plan (ISP), whereby all said parties are invited and participate in the planning process.**<br>**Client #1 has always had a prn order for the dressing/taping of wrists in an incident of a wound resulting from self-injurious behavior. According to the order, the dressings should be changed by a licensed professional twice daily.**<br>**Client # 1 has an attorney, but no legal guardian and family involvement. In September, 2006, the Qualified Mental Retardation Professional (QMRP) filed medical and psychological affidavits with the Department on Disability Services (DDS) for a legal guardian for client#1.**<br>**04/18/07** | |

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| W 124 | Continued From page 2<br>1. During evening observations between 4:15pm and 6:25pm on 3/13/2007, Client #1 was observed scratching her arms, picking at her skin on several occasions, and was observed to bite her hand on two occasions as she sat in her chair in the living room. At 4:40pm on 3/13/2007, the nurse on duty was asked about the white wrist tape that was on both of Client #1 ' s wrists and the nurse indicated they were there to " protect her when she bites her wrist ... they are changed twice a day " . Review of Client #1 ' s Behavior Support Plan dated 10/2/2006 revealed the wrist biting was to be addressed via a list of proactive strategies where staff was to engage in various treatment interventions prior to the onset of the wrist biting or immediately thereafter. The BSP did not indicate that taping this client ' s wrists was a proactive measure for managing Client #1 ' s wrist biting. Moreover, it was not clear how long this client ' s wrists were to be taped. The nurse ' s indication of the wrap being changed twice a day does not indicate how it was to be managed across a 24hr time period. There was no evidence that a plan has been devised to include the wrist taping as a means of managing Client #1 ' s maladaptive behavior of wrist biting. In addition, there was also no written informed consent on file at the time of survey to substantiate that this proactive measure had been approved for implementation.<br><br>2. During the evening med-pass at 7:15pm on 3/13/2007, Client #1 was observed being provided a drug regimen of 100mg of Lopressor and 300mg of Seroquel. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) at 3:05pm on 3/14/2007 revealed Client #1 was without a legally appointed advocate to secure consents for treatment. There was no | W 124 | **W 124 (2)**<br>**On April 2nd, 2007, DDS filed with the court, a request for legal guardian for client #1. Once a guardian is appointed for client #1, consents for helmet use, taping of the wrists, and medications regimen will be obtained.**<br>**Client #2 has on file a signed consent for psychotropic medication use.**<br>**04/18/07** | |

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| W 124 | Continued From page 3<br>evidence on file, at the time of survey, to substantiate that written informed consent had been obtained for Client #1 ' s medication regimen<br><br>3. During the evening med-pass at 7:01pm on 3/13/2007, Client #2 was observed being provided a drug regimen of 3mg of Risperdal, 500mg of Tegretol, and 1500mg of Keppra of which the Tegretol was increased from 400mg to 500mg on 1/26/2007. The Risperdal is being used to manage this client ' s behavior. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) at 3:01pm on 3/14/2007 revealed all documented evidence of consent for the administration of these medications being administered for Client #2 was being held at the main office. There was no evidence on file at the time of survey to substantiate that written informed consent had been obtained for Client #2 ' s medication regimen. | W 124 | **W 124, 3**<br>**A written consent for psychotropic medication use has been filed in client #2's records.**<br>**04/18/07** | |
| W 130 | 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure client privacy during times of personal care for one of three sampled clients. [Client #4]<br><br>The finding includes:<br><br>During afternoon observations at 4:55pm on 3/13/2007, Client #4 was observed lying in his | W 130 | | |

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| W 130 | Continued From page 4<br>bed with his lower body exposed as his attending staff provided his personal care. Client #5 was also in the room at the same time. In addition, the exterior door in this room was also left open to the backyard and deck. The adjoining homes in the area can be seen from this rear door. During the personal care, the attending staff made no effort to shut this door or have Client #5 removed from the room. The facility failed to implement an effective system to ensure client privacy. | W 130 | **W 130**<br>**Thirty minutes prior to the entering of the surveyors to the facility, the CEO, in consonance with the QMRP had in-serviced Direct Care Staff (DCS) on issues pertaining to privacy, dignity, and respect.**<br>**The staff who committed this gross violation has been terminated given the fact that he was in-serviced on the above-mentioned subject thirty minutes prior to the surveyors entering the facility.**<br><br>**Staff have been in-serviced again on the subject of privacy, dignity, and respect. The House Manager and QMRP will, on a weekly basis remind staff to preserve client privacy, dignity, and respect.**<br>**The social worker will, on a quarterly basis in-service staff on the above-mentioned subjects.**<br>**04/18/07** | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS<br><br>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.<br><br>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure an observed injury was reported as required by this section for one of three sampled clients. [Client #1]<br><br>The finding includes:<br><br>During evening observations at 4:45pm on 3/13/2007, two parallel scratch marks approximately 4 ½ inches long and ½ inch apart were observed on Client #1's right arm. The scratches appeared red and the skin was broken. The facility's House Manager was asked about the origin of those scratches and she replied that "it probably happened at the Day Program." The scratch marks were markedly different from the other smaller marks on this client's arms and | W 153 | | |

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| W 153 | Continued From page 5<br>hands. Record review revealed that Client #1 has a history of Self Injurious Behaviors, but it was not clear if the injury observed was of this client's doing or not. On 3/14/2007, the Incident Reports were reviewed a second time and there was no indication that the scratches were identified or reported. There was no evidence on file at the time of survey to substantiate that the facility ensured compliance with the requirements of this section. | W 153 | **W 153**<br>**A form has been developed to track, report, and investigate injuries of unknown origin. Staff have been in-serviced on incident reporting policies and procedures. The House Manager will on a daily basis monitor the completion of the incident tracking form.**<br><br>**With reference to the scratches on client #1's arm, an incident report has been generated, and an investigation completed. These documents have been filed in client #1's records.**<br>**04/18/07** | |
| W 154 | 483.420(d)(3) STAFF TREATMENT OF CLIENTS<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that all injuries of unknown origin were invested for one of the three sampled clients. [Client #1]<br><br>The finding includes:<br><br>Record review on 3/14/2007 revealed that the injury observed on Client #1's right arm on 3/13/2007 was neither reported nor investigated. [Reference W153] | W 154 | **W 154**<br>**Cross reference W153.**<br>**04/18/07** | |
| W 158 | 483.430 FACILITY STAFFING<br><br>The facility must ensure that specific facility staffing requirements are met.<br><br>This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to ensure that each client's active treatment program was | W 158 | | |

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| | 09G148 | | 03/16/2007 |

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| W 158 | Continued From page 6<br>integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) [See W159]; and failed to ensure sufficient support staffing to ensure supervision and effective monitoring of clients and their personal needs [See W185]; failed to ensure sufficient direct care staff to ensure supervision and effective monitoring of clients and their personal needs; and the facility staff failed to demonstrate competency in implementation of Client's Behavior Support Plans [See W193].<br><br>The effects of these systemic practices results in the facility's failure to provide adequate client protection, and active treatment supports. [See W124, W130, W153, W154, W196, W247, W249, and W252] | W 158 | **W 158**<br>**Key goals for the QMRP in the upcoming quarter (May 2007 to July 2007) are: to embark on intensive staff training in areas of active treatment; monitoring; implementation of behavior support plans; and maximization of the overall welfare of the clients in this population. The QMRP will spend at least four days in the week at this facility to ensure that staff are adequately trained and are implementing active treatment programs as specified.**<br><br>**The psychologist will provide quarterly training on the behavior support plans for client # 1 and client #2.**<br><br>**04/18/07** | |
| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>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 manage the coordination of services to ensure client protections; failed to ensure the provision of competent and trained staff; failed to ensure the coordination of services to ensure continuous and aggressive active treatment; and failed to ensure the provision of adaptive equipment for four of six clients residing in the facility.<br><br>The findings include: | W 159 | | |

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| W 159 | Continued From page 7<br>1. The QMRP failed to ensure protective measures to prevent client head injury. [Reference W249(#2)]<br><br>2. The QMRP failed to ensure proactive measures to ensure client protections. [Reference W124, W130, W153, and W154]<br><br>3. The QMRP failed to ensure the provisions of adequate support staff and failed to ensure that the facility ' s staff was effectively trained to manage the treatment needs of four of the six clients in the facility. [Reference W159, W185, W189, and W193]<br><br>4. The QMRP failed to ensure that clients received and aggressive and continuous active treatment regimen to manage and ultimately control client ' s maladaptive behaviors. [Reference W196, W247, W249, W252, and W263]<br><br>5. The QMRP failed to ensure that client ' s received the usage of prescribed helmets and foot orthotics for two of three sampled clients. [Reference W436] | W 159 | **W 159 (1)**<br>**Client #2 is being provided with the correct (prescribed) helmet.**<br><br>**W 159 (2)**<br>**Cross reference W124, w130, W 153, and W154.**<br><br>**W 159 (3)**<br>**The facility is now fully staffed. In the upcoming quarter, the QMRP will embark on intensive staff training so as to ensure effective provision of services.**<br><br>**W 159 (4)**<br>**See W196, W247, W249, W252, and 263.**<br><br>**W159 (5)**<br>**Client # 1 and client #2 are being provided with the prescribed helmet and ankle foot orthosis respectively. The QMRP will, on a monthly basis keep track of wear and tear status of adaptive equipments and submit on a timely basis the necessary paper work for repairs or replacement.**<br>**04/18/07** | |
| W 185 | 483.430(c)(4) FACILITY STAFFING<br><br>The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.<br><br>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failure to ensure adequate support staffing affected the personal care needs | W 185 | | |

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| W 185 | Continued From page 8<br>and the meal services of two of the five clients residing in the facility. [Clients #4 & #5]<br><br>The findings include:<br><br>1. During evening observations at 4:10pm on 3/13/2007, Client #4 and Client #5 were observed being escorted off the facility van, up the rear deck and into their bedroom. As staff wheeled Clients #4 and #5 passed the survey team at approximately 4:19pm, a strong foul odor was detected. At that time, the survey team was not sure of the origin of the odor. Both of the clients were wheeled into their room from the rear deck. The rear door was left open while Direct Care Staff #1 attended to Client #1 and #2 ' s personal care. At 4:48pm, the nurse on duty asked Direct Care Staff #1 if he had checked on Client #4. The staff responded that he was told Client #5 was changed at his Day Program; therefore, he did not think to check on Client #4. This surveyor followed Direct Care Staff #1 down the hall to Client #4 ' s bedroom. Again, a strong odor was detected in the hallway leading to Client #4 ' s bedroom. When Direct Care Staff #1 checked Client #4, he found that he had a bowel movement and needed to be washed and his clothing changed. Client #4 was allowed to sit in his room between 4:19pm and 4:50pm with soiled undergarments until Direct Care Staff #1 started his personal care. It should be noted that between 4:19pm and 4:48pm, Direct Care Staff #1 was involved in both preparing the evening dinner and helping arrange the dining area to accommodate the other clients with their evening routine. Additionally, between 4:30pm and 4:48pm, Direct Care Staff #1 was also involved in preparing dinner. | W 185 | **W 185 (1)**<br>**Direct Care Staff #1 has been terminated given that he failed to timely attend to client needs despite he was reminded by the nurse on duty repeatedly to check and attend to client needs.**<br><br>**The House Manager and a nurse on duty will, on a daily basis complete a monitoring chart which will have components of timely checking and changing of clients upon returning home, preservation of privacy while attended to, and timely provision of other specified services according to their health needs.**<br>**04/18/07** | |

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| W 185 | Continued From page 9<br>2. During evening observations on 3/13/2007 at 4:19pm, Client #5 was wheeled into the facility and into his bedroom when he arrived home from his Day Program. At approximately 4:30pm Client #5 was wheeled into the living room by Direct Care Staff #1 and placed near the wall next to Client #6. At approximately 4:48pm Direct Care Staff #1 had to address a personal needs issue for Client #4 and left Client #5 in the living room. Between 4:48pm and 5:10pm Clients #1, #2, and #4 were being fed their snacks at the dining room table in direct view of Client #5. Client #5 was left watching the others eat while his attending staff (Direct Care Staff #1) was addressing Client #4 's personal needs. At approximately 5:11pm Direct Care Staff #1 wheeled Client #4 into the dining room, rearranged the dining area to accommodate his wheelchair and fed Client #4 his snack. Once the snacks were all consumed, the dining room was again rearranged for dinner. Client #5 was sitting in an area where he was able to see the activities, but was not afforded the opportunity to have any snack with his peers. With the various activities going on around the dining room, attending to meal preparations, rearranging of furniture, and managing another client's spitting episodes, no one realized that Client #5 was not afforded the opportunity to have his afternoon snack. | W 185 | **W 185 (2)**<br>**This was an oversight. The QMRP has developed a "meal serving checklist" to ensure that staff will be tracking how often meals are served, and to ensure that all clients are provided with opportunities to have their meals at all given times.**<br>**04/18/07** | |
| W 189 | 483.430(e)(1) STAFF TRAINING PROGRAM<br>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.<br>This STANDARD is not met as evidenced by: Based on interview and record review, the facility | W 189 | | |

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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 |
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| | 09G148 | | 03/15/2007 |

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

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| W 189 | Continued From page 10<br>failed to ensure that each employee implement behavior management plans as written; failed to ensure adequate personal care; and failed to demonstrate consistent documentation of client performance as required by their Individual Program Plans for two of three sampled clients. [Clients #1, #2 and #4]<br><br>The findings include:<br><br>1. The observations of client care on 3/13/2007 and subsequent record reviews revealed the facility ' s Direct Care staff failed to implement behavior management plans as written; failed to ensure adequate personal care; and failed to demonstrate consistent documentation of client performance as required by each client ' s Individual Program Plans. There was no evidence that effective training has been implemented to ensure the implementation of active treatment plans and the overall safety and well being of two of three sampled clients of three of six clients residing in the facility.<br><br>2. Interview with the facility's house manager at 5:30pm on 3/13/2007 and with the facility ' s Qualified Mental Retardation Professional at 2:55pm on 3/14/2007 revealed that Direct Care Staff #1 works across several houses within the agency to " fill-in " wherever staffing was limited. This direct care staff was new to this facility and it was not clear how long he has been at this location. Interview with Direct Care Staff #1 at 5:45pm on 3/13/2007 revealed he has been at this facility for five weeks. The QMRP indicated during his interview on 3/14/2007 that this direct care staff has only been at the facility for two weeks. Record review failed to reflect that this staff was provided the necessary training and | W 189 | **W 189 (1)**<br>**The QMRP and Direct Care Staff have been in-serviced on implementation of behavior support plans, accurate collection and documentation of behavior data. See herewith. The psychologist will, on a quarterly basis in-service staff on the above-mentioned areas to ensure effective data collection.**<br>**04/18/07**<br><br>**W 189 (2)**<br>**For new hires, the QMRP will, on a monthly basis coordinate staff training with the Department on Disability Services (DDS) in areas such as implementation of behavior support plans, incident management, accurate collection and documentation of behavior data, implementation of Individual Support Plan (ISP) goals, and preservation of client privacy, dignity and respect (See evidence of DDS's monthly training calendars). The House Manager will, on a daily basis monitor the effectiveness of the above-mentioned trainings through proper implementation.**<br>**04/18/07** | |

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

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G148 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/15/2007 |
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|---|---|---|---|---|
| W 189 | Continued From page 11<br>orientation required for managing the personal and behavioral needs of Clients #1, #2, #3, and #4. [Reference W193, W185, W249]<br><br>3. The observations of client care on 3/13/2007 and subsequent record reviews revealed the facility ' s Direct Care staff failed to implement behavior management plans as written; failed to ensure adequate personal care; and failed to demonstrate consistent documentation of client performance as required by each client ' s Individual Program Plans. There was no evidence on file to substantiate that the facility ' s staff was provided adequate and effective training to ensure the health, safety and well-being of its clients. This systemic breakdown is evidenced in the failures cited in the area of Active Treatment. [Reference W193, W195, W196, W247, W249, W252] | W 189 | **W 189 (3)**<br>**Cross reference W189 (2)**<br>**04/18/07** | |
| W 193 | 483.430(e)(3) STAFF TRAINING PROGRAM<br><br>Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.<br><br>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 implementation of Client #1's Behavior Support Plan (BSP).<br><br>The findings include:<br><br>During evening observations on 3/13/2007 between 4:10pm and 7:40pm Client #1 was observed exhibiting several of her targeted maladaptive behaviors (i.e. skin picking, scratching, wrist biting, etc). The facility ' s direct | W 193 | **W 193**<br>**Staff have been trained on the behavior support plans for client #1 and client# 2. The psychologist will, on a quarterly basis in-service staff on proactive measures, interventions to behavior management, and documentation of behavior episodes. The House manager will, on a weekly basis monitor staff to ensure compliance.**<br>**04/18/07** | |

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

PRINTED: 04/05/2007
FORM APPROVED
OMB NO. 0938-0391

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| | 09G148 | | 03/15/2007 |

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|---|---|---|---|---|
| W 193 | Continued From page 12<br>care staff failed to implement the proactive strategies as prescribed in this client ' s behavior management plan. Staff was also observed to reinforce some of the maladaptive behaviors that were being exhibited by this client because they were not implementing the proactive measures as presented in the written plan. [Reference W249] | W 193 | | |
| W 195 | 483.440 ACTIVE TREATMENT SERVICES<br><br>The facility must ensure that specific active treatment services requirements are met.<br><br>This CONDITION is not met as evidenced by: Based observations, interviews, and record reviews, the facility failed to provide a continuous and comprehensive developmental and behavioral care to address the safety, health and well being of a client [W196]; the facility failed to ensure client choice during meals [W247]; the facility failed to implement active treatment programs as written [W249]; the facility failed to ensure that staff documented data are accurate, (i.e., reflective of actual individual performance) [W252]; and the facility's specially constituted committee failed to ensure that consents were obtained prior to the use of medications for behavior management. [W263]<br><br>The findings of these systemic practices results in the facility's failure to adequately govern the facility in a manner that would ensure its clients' are provided active treatment to identify and meet their identified needs. | W 195 | **W 195**<br>**Please refer to: W196; W 247; W249; W252; and W 263.**<br>**04/18/07** | |
| W 196 | 483.440(a)(1) ACTIVE TREATMENT<br><br>Each client must receive a continuous active treatment program, which includes aggressive, | W 196 | | |

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

PRINTED: 04/06/2007
FORM APPROVED
OMB NO. 0938-0391

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| | 09G148 | | 03/15/2007 |

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|---|---|---|---|---|
| W 196 | Continued From page 13<br>consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:<br>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and<br>(ii) The prevention or deceleration of regression or loss of current optimal functional status.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure clients received a continuous active treatment program, which includes aggressive, consistent implementation of a behavioral management program, for two of the three sampled clients. [Client #1]<br><br>The findings include:<br><br>1. During evening observations between 4:15pm and 6:25pm on 3/13/2007, the facility failed to " prevent [maladaptive] behavior by encouraging [Client #1] to point to appropriate, desired objects " as prescribed in her Behavior Support Plan. [Reference W249, Citation #1(a)]<br><br>2. During evening observations between 4:15pm and 6:25pm on 3/13/2007, the facility failed to " prevent [maladaptive] behavior by encouraging [Client #1] to gesture pain, needs, and/or discomfort " as prescribed in her Behavior Support Plan. [Reference W249, Citation #1(b)]<br><br>3. During evening observations between 4:15pm and 6:25pm on 3/13/2007, the facility failed to ensure that Client #1 " not allow her to sit idle for | W 196 | **W 196 (1)**<br>**Staff have been trained on the behavior support plans for client #1 and client# 2. The psychologist will, on a quarterly basis in-service staff on proactive measures, interventions to behavior management, documentation of behavior episodes, and the use of helmet for client #1 during waking hours. The House manager will, on a weekly basis monitor staff to ensure compliance.**<br>**04/18/07** | |

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

PRINTED: 04/05/2007
FORM APPROVED
OMB NO. 0938-0391

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| | 09G148 | | 03/15/2007 |

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

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|---|---|---|---|---|
| W 196 | Continued From page 14<br>long periods of time " as prescribed in her Behavior Support Plan. [Reference W249, Citation #1(c)]<br><br>4. During evening observations at 4:15pm 3/13/2007, the facility failed to "give [Client #1] at least five minutes advance notice when a change of activities or location was going to occur" as prescribed in her Behavior Support Plan. [Reference W249, Citation #1(d)]<br><br>5. During evening observations between 4:15pm and 6:25pm on 3/13/2007, the facility failed implement the prescribed interventions to help Client #1" decrease self-injurious behavior and aggressive behaviors " as prescribed in her Behavior Support Plan. [Reference W249, Citation #1(e)]<br><br>6. Observations between 4:15pm and 7:40pm on 3/13/2007 revealed the facility failed to ensure that Client #1 " wear her helmet during waking hours to prevent injury to her head" as prescribed in her Behavior Support Plan. [Reference W249, Citation #2]<br><br>7. Observation between 4:15pm and 7:40pm on 3/13/2007 revealed the facility failed to " ignore " Client #2 as prescribed in her Behavior Support Plan. [Reference W249, Citation #3] | W 196 | W 196 (2), (3), (4), (5), (6) & (7)<br><br>Cross reference W196 (1)<br><br>04/18/07 | |
| W 247 | 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan must include opportunities for client choice and self-management.<br><br>This STANDARD is not met as evidenced by: Based on observation and staff interview, the | W 247 | | |

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OMB NO. 0938-0391

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

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|---|---|---|---|
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|---|---|---|---|---|
| W 247 | Continued From page 15<br>facility failed to ensure that clients were allowed the opportunity to exercise their rights for meal choices during dinner for two of three clients residing in the facility. [Clients #1 and #5]<br><br>The findings include:<br><br>1. During dinner observations at 6:36pm on 3/13/2007, Client #1 was observed eating a pureed meal of stewed chicken, fried rice, and peaches. While staff was aiding this client to eat her meal, the staff tipped the plate over by mistake and the three sections of food mixed together and fell on Client #1 ' s bib. The pureed peaches and chicken spilled over into each other and some of the fried rice that was in Client #1 ' s mouth also spilled into the peaches as the staff worked to control the spillage of food when the plate tipped over. After the staff cleaned off Client #1 ' s bib and readjusted the plate onto the table in front of the client, the staff continued to feed Client #1 her meal. The staff served the mixture of peaches and chicken to the client and also served the mixture of regurgitated rice and peaches to her as well. Client #1 ate all of what was left in her plate after it tipped over. At no time did staff take an account of the " mixed " food nor offered the client the opportunity to choose a fresh plate of food.<br><br>2. During dinner observations at 6:36pm on 3/13/2007, Client #5 was observed being served a pureed meal of stewed chicken, fried rice and peaches. Client #5 was observed to eat the first three spoons of food that staff gave him. About the fourth or fifth spoon of food, Client #5 began to grimace, turn his head away, and firm his mouth shut as staff attempted to serve him his meal. The attending staff continued to feed Client | W 247 | **W 247 (1)**<br>**Staff have been in-serviced by the social worker in areas of providing choices during meals, and active treatment. The QMRP will, put a notice of reminder in all active treatment records reminding staff to provide choices during meals and other activities, and not to return spilled food into a client plate.**<br>**04/18/07** | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|---|---|---|---|---|
| W 247 | Continued From page 16<br>#5 hi s meal but Client #5 appeared to growing more reluctant to eat. During that process, the staff was being met with increasing resistance with each additional spoon of food and had to raise his tone of voice to gain compliance. It was not clear what prompted Client #5 to resist the subsequent feeding attempts after the first couple of spoons, but staff was not observed to offer this client any additional choice(s) of items to eat. | W 247 | **W 247 (2)**<br>**The social worker has in-serviced staff on providing clients with choices during meals and active treatment. Staff is being advised to adhere to client #5's mealtime protocol. The House Manager, and/or a nurse on duty, will on a daily basis supervise staff in meeting the needs of client #5 during meal time.**<br>**04/18/07** | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to ensure that clients receive interventions as specified in their behavior management plans for two of three sampled Clients. [Clients #1 and #2]<br><br>The findings include:<br><br>1. During evening observations between 4:15pm and 6:25pm on 3/13/2007, Client #1 was observed scratching her arms, picking at her skin on several occasions, and was observed to bite her hand on two occasions as she sat in her chair in the living room. Record review revealed this client ' s Psychologist prescribed several proactive interventions which were created to | W 249 | | |

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

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OMB NO. 0938-0391

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|---|---|---|---|---|
| W 249 | Continued From page 17<br>manage and ultimately lessen the frequency of this client ' s maladaptive behaviors as outlined in her 10/2/2006 Behavior Support Plan (BSP) The recommendations and the facility ' s failure to comply with these recommendations are presented below:<br><br>a. Recommendation #1: To " prevent [maladaptive] behavior by encouraging [Client #1] to point to appropriate, desired objects, as she has some functional vision ... staff should provide verbal reinforcement whenever [Client #1] points to a desired, appropriate object. " The facility ' s staff was never observed to implement this intervention prior to the onset of Client #1 ' s scratching, picking and wrist biting. The facility ' s staff did not interact with this client during the period she was allowed to sit idle apart from when the gloves were being put on/taken off her hands. The facility failed to ensure that this client was afforded the opportunity to express her wants as prescribed by this treatment plan and failed to implement her behavioral support plan as prescribed.<br><br>b. Recommendation #2: To " prevent [maladaptive] behavior by encouraging [Client #1] to gesture pain, needs, and/or discomfort ... staff should provide verbal reinforcement whenever [Client #1] gestures pain, needs, and/or discomfort. " The facility ' s staff was never observed to implement this intervention prior to the onset of Client #1 ' s scratching, picking and wrist biting. In addition, the staff also did not stop to assess the needs, pain or discomfort level of this client after she began to exhibit her targeted behaviors. The facility ' s staff did not interact with this client during the period she was allowed to sit idle apart from when the gloves were being | W 249 | **W 249 (1a)**<br>**Cross reference W196 (1).**<br><br>**W 249 (1b)**<br>**Cross reference W196 (1).**<br>**04/18/07** | |

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

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|---|---|---|---|---|
| W 249 | Continued From page 18<br>put on/taken off from her hands. The facility failed to ensure that this client was afforded the opportunity to express her needs, pain and/or discomfort level and failed to implement her behavioral support plan as prescribed.<br><br>c. Recommendation #3: The facility should "not allow [Client #1] to sit idle for long periods of time" as a proactive measure to manage her maladaptive behaviors. Client #1 was observed sitting in a chair in the living on 3/13/2007 from 4:15pm to 6:25pm with little to no staff interaction. The facility ' s staff did not interact with this client during the period of observation apart from when the gloves were being put on/taken off from her hands. The facility failed to ensure this client was afforded the opportunity to be engaged in " any " constructive activity as prescribed in her treatment plan.<br><br>d. Recommendation #4: To manage client.' s maladaptive behavior, " give [Client #1] at least five minutes advance notice when a change of activities or location was going to occur". At 4:15pm, Client #1 was escorted from the facility van, taken to a chair in the living room (near the dining room table) and allowed to sit for approximately 12 minutes as the other three clients were escorted from the van. Once everyone was in the facility, staff then escorted her to her bedroom and she was allowed to sit for another few minutes before she was escorted to the bathroom to have her undergarments changed. She sat in her room for approximately 5 minutes before staff escorted her back to the chair in the living room. Later on at approximately 6:23pm, staff escorted her to the dining room table for dinner. At no time was Client #1 observed to be afforded the "five minutes | W 249 | **W 249 (1c)**<br>**Cross reference W196 (1).**<br><br>**W 249 (1d)**<br>**Cross reference W196 (1).**<br>**04/18/07** | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| W 249 | Continued From page 19<br>advance notice" as recommended by her Behavior Support Plan. The facility failed to ensure that this client ' s behavioral interventions were implemented as prescribed.<br><br>e. Recommendation #5: As a proactive measure, "gloves should be placed on [Client #1 ' s] hands only if she does not respond to verbal prompts to cease skin picking behavior ... gloves will be worn for two-hour increments and removed at the end of the two-hour period ... If skin picking resumes. staff will again give [Client #1] one verbal prompt to stop the behavior. If she does not respond to the verbal prompt and continue to engage in skin picking, the gloves will again be placed on [Client #1 ' s] hands. " The facility ' s staff did not interact with this client during the period of observation apart from when the gloves were being put on/taken off from her hands. In addition, the facility ' s staff did not enforce the measure of verbally prompting this client to stop the skin picking prior to implementing the gloves. The direct care staff also did not utilize the gloves in the proper duration as prescribed in this client ' s treatment plan.<br><br>On each occasion that a direct care staff intervened, the gloves were removed 10 minutes later. In addition, on each occasion where the gloves were implemented, staff did not verbally redirect Client #1 before using the gloves on her hands. Staff was observed to redirect Client #1 " as " the gloves were being placed on her hands. The facility failed to ensure the proper implementation of this restrictive measure as prescribed in Client #1 ' s BMP.<br><br>2. Observations between 11:30am and 12:30pm | W 249 | W 249 (1e)<br>Cross reference W196 (1).<br>04/18/07 | |

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

PRINTED: 04/05/2007
FORM APPROVED
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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 |
|---|---|---|---|
| | 09G148 | | 03/15/2007 |

NAME OF PROVIDER OR SUPPLIER: WHOLISTIC 03

STREET ADDRESS, CITY, STATE, ZIP CODE: 1914 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 249 | Continued From page 20<br>on 3/14/2007 revealed that Client #1 was observed eating her lunch at her day program without wearing her helmet. The floor in the dining hall at her day program appears to be a polished concrete floor. Staff at the day program indicated that she was allowed to eat her lunch without wearing her helmet as a normal routine. Upon reaching the residential facility, the facility's QMRP was asked about Client #1's helmet use and at 2:44pm on 3/14/2007 he stated that he "allows [Client #1] to take her helmet off whenever she's not having any behaviors." Record review revealed Client #1's BSP dated 10/2/2007 recommends "[Client #1] should wear her helmet during waking hours to prevent injury to her head." The facility failed to ensure that this client's behavioral interventions were implemented as prescribed.<br><br>3. During evening observation between 4:15pm and 7:40pm, Client #2 was observed to spit at staff approximately eight times. Record review revealed Client #2's Behavior Support Plan outlines the strategy to "address spitting behavior when it occurs by moving others out of [Client #2's] direction. Firmly instruct her to stop spitting, then attempt to ignore her (to the safest extent possible) while she was still spitting." It should be noted that while Client #2 was observed spitting at a female support staff on 3/13/2007, she was in constant contact and communication with a male staff that was helping her put together a puzzle. The facility's Qualified Mental Retardation Professional (QMRP) at 2:17pm on 3/14/2007 indicated during interview that only the person that was spat on was to ignore Client #2 when she's engaged in her spitting episodes. There was no evidence of file to substantiate this interpretation given by the | W 249 | **W 249 (2)**<br>**A case conference was held with the day program on 04/17/07 to discuss implementation of client #1's behavior support plan. Also, the residential facility had an in-service on 04/09/07 on issues pertaining to the behavior management plans. During the in-service, the psychologist clarified how often client #1 should have her helmet on – "client #1 should wear her helmet during waking hours."**<br>**04/16/07**<br><br>**W 249 (3)**<br>**The psychologist has addressed the issue of who is to ignore client #2 when she is spitting at someone.**<br>**Staff have been in-serviced on how to intervene when client #2 is spitting at someone.**<br>**04/09/07** | |

CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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|---|---|---|---|---|
| W 249 | Continued From page 21<br>QMRP nor was there evidence that the written plan had been clarified to ensure that staff implemented the treatment plan as prescribed. The facility failed to ensure that this client's behavioral interventions were implemented as prescribed. Note: There were several occasions when the survey team was out of direct sight of the Client #2 ' s spitting incidents, but could hear staff complaining about Client #2 ' s spitting and asking her to stop. | W 249 | | |
| W 252 | 483.440(e)(1) PROGRAM DOCUMENTATION<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the implementation of an effective system of documenting the frequency of maladaptive behaviors as recommended in a Client ' s behavior management plan for two of three sampled Clients. [Clients #1 & #2]<br><br>The findings include:<br><br>1. During evening observation between 4:15pm and 7:40pm, Client #1 was observed picking at her skin on 3 occasions and scratching her arms on approximately 12 occasions. Each instance of both the skin picking and the scratching lasted approximately 3 - 7 seconds in duration. Record review on 3/14/2007 revealed that these instances were not documented on the behavioral data collection sheets. Further record review | W 252 | | |

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

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| | 09G148 | | 03/15/2007 |

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|---|---|---|---|---|
| W 252 | Continued From page 22<br>revealed that Client #1's Behavioral Support Plan (BSP) dated 10/2/2006 prescribes to "document on the ABC Data Collection Form each time [Client #1] displays: 1) Self-injurious Behavior (wrist biting, head banging, skin picking and scratching." This monitoring tool devised in the BSP provided a means for assessing the progress and the effectiveness of the behavioral interventions (proactive strategies). The facility failed to implement the data collection as prescribed by the BSP.<br><br>2. During evening observation between 4:15pm and 7:40pm, Client #2 was observed to spit at staff approximately eight times. The most egregious incident occurred when staff was preparing the table for dinner and Client #2 spit directly on the support staff's face. The support staff became very agitated and stated that "she's been spitting at me all afternoon." The facility's Nurse on duty advised the staff that she should be documenting these episodes. That support staff responded, "I'm definitely documenting this one." Record review on 3/14/2007 revealed the episodes of spitting that were observed by the survey team was not documented in Client #2's data collection sheets. Review of Client #2's Behavior Support Plan dated 4/4/2006 revealed the facility staff was to document when this client spits "on or at people". There was no evidence that staff has ensured accurate documentation of Client #2's maladaptive behavior of spitting on and spitting at people as required by her treatment plan. | W 252 | **W 252 (1)**<br>**Staff have been trained on effective data collection. The psychologist will, on a quarterly basis train staff on accurate documentation of behavior data.**<br>**The House Manager will, on a daily basis monitor staff to ensure that behavior data are accurately documented.**<br>**04/18/07**<br><br>**W 252 (2)**<br>**Cross reference W 252(1).**<br>**04/18/07** | |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE<br><br>The committee should insure that these programs are conducted only with the written informed | W 263 | | |

PRINTED: 04/05/2007
FORM APPROVED
OMB NO. 0938-0391

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

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|---|---|---|---|---|
| W 263 | Continued From page 23<br>consent of the client, parents (if the client is a minor) or legal guardian.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that programs which incorporate restrictive techniques and the use of medications to control behaviors were conducted only with the written informed consent of the client or legal guardian for two of the four clients included in the sample. (Clients #1 and #3)<br><br>The findings include:<br><br>1. There was no evidence that written informed consent had been obtained for restrictive intervention used as a part of a Behavior Support Plan to include wrist bands, helmet, gloves and psychotropic medications for Client #1. [Reference W124]<br><br>2. There was no evidence that written informed consent had been obtained for restrictive intervention used as a part of a Behavior Support Plan to include psychotropic medications for Client #2. [Reference W124] | W 263 | **W 263 (1)**<br>**Cross reference W124**<br>**04/18/07**<br><br>**W 263 (2)**<br>**Client #2's signed consent for psychotropic medication use has been filed in her records at the facility. See evidence herewith.**<br>**04/18/07** | |
| W 382 | 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation of the medication administration, the facility failed to ensure the security of medications during medication | W 382 | | |

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

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|---|---|---|---|---|
| W 382 | Continued From page 24<br>administration for two of three clients residing in the facility. [Clients #2 and #4]<br><br>The findings include:<br><br>1. During observation of the evening med-pass between 6:58pm and 7:19pm on 3/13/2007, the facility's Trained Medication Employee (TME) was observed walking upstairs from the basement with a tray of medications to be administered to Clients #1, #2, and #4. This medication tray consisted of packaged sets of Lopressor, Seroquel, Timolol, Tegretol, Depakote, Ferrous Sulfate, and Risperdal in various dosages and quantities to be dispensed to Clients #1 and #2. The facility's TME started her administration of the medications with Client #4. She entered his room and placed the medications on a table next to where Client #4 was seated in his wheelchair. The small table she used was well within arm's reach for Client #4. At that point she realized she didn't have on any gloves, so she exited the room and went down the hall and into the living area to get her a pair of rubber gloves. Approximately two minutes later she returned and commenced her routine and provided Client #4 his evening medications. The TME failed to ensure the security of the medications during a medication administration.<br><br>2. During observation of the evening med-pass between 6:58pm and 7:19pm on 3/13/2007, the facility's Trained Medication Employee (TME) walked into Client #2's room after providing Client #4 his medications. She entered the room and placed Client #2's medications on a small table in this client's room. One of the facility's direct care staff walked Client #2 into her room for her evening medications. The TME again | W 382 | **W 382 (1)**<br>**The TME in question was not supposed to administer medication at this facility, because there is always a Licensed Practical Nurse (LPN) on shift who is charged with medication administration.**<br><br>**However, the said TME has been in-serviced on medication administration protocol, which includes: assembling of equipment before medication administration; securing of medication; administration, and documentation.**<br><br>**The facility RN will, on a quarterly basis in-service TMEs on medication administration protocols.**<br>**04/18/07**<br><br>**W 382, 2**<br>**Cross reference W382, 1**<br>**04/18/07** | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|---|
| W 382 | Continued From page 25<br>realized that she needed a fresh pair of gloves and exited the room to get a fresh pair of rubber gloves. On her way out of Client #2 ' s room, she pulled the door shut behind her. [The survey team cracked the door to keep an eye on Client #2 while the TME was away from the room.] Approximately, two minutes later the TME returned and began to provide Client #2 with her evening medications. The TME failed to ensure the security of the medications during a medication administration | W 382 | | |
| W 436 | 483.470(g)(2)/SPACE AND EQUIPMENT<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br><br>This STANDARD is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure clients are provided prescribed headwear (helmet); failed to ensure that clients received prescribed Orthotic footwear; failed to ensure the proper provision of compression socks; and failed to ensure that client ' s wheelchairs are in good working order for three of six clients residing in the facility. [Clients #1, and #2]<br><br>The findings include:<br><br>1. During evening observation between 4:15pm and 7:40pm on 3/13/2007 Client #1 was observed reaching under her helmet and scratching her head on three different occasions. This client | W 436 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| W 436 | Continued From page 26<br>was able to fit her hand underneath her helmet and scratch several areas of her head while her helmet was still strapped on. On each episode, after she finished scratching her head, she moved the helmet from side to side in effort to reposition it squarely on her head. The helmet appeared to be grossly oversized for her head even when the chin straps were securely fastened. Record review revealed that Client #1 was fitted for a better fitting helmet on 2/26 /2007 as indicated in her quarterly Physical Therapy assessment. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) at 2:23pm on 3/14/2007 revealed Client #1 ' s new helmet was completed and delivered to the home approximately two weeks ago. He showed the survey team the new helmet and further explained that he chose not to provide it to [Client #1] because he felt the current helmet was in " good condition " and didn ' t need to be replaced. The facility failed to ensure that Client #1 was provided the proper and necessary adaptive equipment to ensure her health and safety as required by both her Physical Therapist and Psychologist.<br><br>2. During evening observation from 4:15pm to 4:35pm pm on 3/13/2007, Client #2 was observed wearing a pair of black leather shoes. The heels and structure of both shoes were extremely worn. The right shoe was constructed with a metal hinged brace attached to it. The back of each shoe was flattened to resemble a pair of " slide on " shoes. Both shoes were poorly fitting and were observed dragging off Client #2 ' s feet as she was wheeled from the van along a small patch of gravel/grass, up the winding ramps of the wooden rear deck and along the floor inside the home as she made her way into the facility. | W 436 | **W 436 (1)**<br>**Client #1 has been provided with the correct helmet. In the future, the facility will adhere to provision of correct adaptive equipment.**<br>**04/18/07** | |

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|---|---|---|---|---|
| W 436 | Continued From page 27<br>This client was later observed walking around the facility in an unsteady fashion as her heels would slip in and out of the shoes and the metal brace along the way. Record review revealed the Day Program held a Case Conference on 8/16/2006 to address the Client #1 ' s need for new shoes. The Day Program also secured a Physical Therapy Assessment dated 1/3/2007 to address the issue and the excerpts from this document details the following:<br><br>a. She has a pair of shoes with a soft leather upper and wood sole. Both shoes are worn and in poor condition.<br><br>b. There was a metal, hinged left ankle foot orthosis attached to the shoe. The leg and ankle straps are worn.<br><br>c. The soles and uppers of both shoes are worn. [Client #1 ' s] heels are not supported in the shoes.<br><br>d. The shoe strings are worn and short. They do not allow the shoes to be laced fully.<br><br>This PT assessment further recommends the following interventions:<br><br>a. [Client #1] would benefit from new shoes. The shoes should have a firm upper to support her foot. A firm heel counter and a straight last sole will address bilateral pes planus<br><br>b. The shoes should be extra-depth with a wide toe box. Consider custom inserts to support pes planus. The inserts should be molded at subtalor neutral. | W 436 | **W 436 (2,a,b,c,d)**<br>**Note: This citation refers to client #2, not client #1. Client #1 does not use adaptive shoes.**<br>**A new pair of shoes has been provided for client #2. A second pair has been ordered through Medicaid.**<br>**In the future, the facility will ensure that client #2 always has a second pair of shoes as a back up.**<br>**04/18/07** | |

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|---|---|---|---|---|
| W 436 | Continued From page 28<br>c. The shoes and brace should be lightweight secondary to her left lower extremity weakness. "<br><br>The facility failed to ensure Client #1 was provided the proper Orthotic support as recommended. There was no evidence at the time of survey to substantiate that this recommendation has been reviewed by the home and addressed as required by this section to maintain the integrity of this client ' s mobility.<br><br>3. Interview with the attending Nurse at Client #1 ' s Day Program at 11:45am on 3/14/2007 revealed he was concerned about the circulation in Client #1 ' s legs due to the poor fit of Client #1 ' s compression socks. Documentation was presented by the Day Program Nurse which showed that a nursing consult was sent from the Day Program to the home to address the importance of the need on 2/2/2007. In addition, the Day Program secured a Physical Therapy assessment on 1/3/2007 which also identified that " [Client #1] was wearing compression socks. The socks gather at her ankles and lower legs which may compromise circulation. " This PT assessment fu rther recommends that " [Client #1] would benefit from custom compression socks. " Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) and Registered Nurse (RN) at 1:44pm on 3/14/2007 revealed they were not aware there still was a concern by the day program about the compression socks. There was no evidence at the time of survey to substantiate that this concern and recommendation for new custom compression socks by the Day Program has been addressed. | W 436 | **W 436 (3)**<br>**Client #2 is currently utilizing the recommended compression socks. The facility has in stock six of the recommended socks as back upin case of wear and tear of the current socks.**<br><br>**Client #2 will continue to be provided with compression socks as recommended by her PT and approved by her primary care physician. The House Manager will, on a daily basis check to ensure that client #2's socks are intact and utilized as prescribed. The facility RN will, on weekly basis monitor client #2 utilization of her compression socks to ensure compliance.**<br>**04/18/07** | |

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Health Regulation Administration

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| I 000 | INITIAL COMMENTS<br><br>A licensure survey was conducted from 3/13/2007 through 3/14/2007. Two males and four females with varying degrees of disabilities reside in the facility. Three of the six residents were randomly selected for the sample. The findings of the survey were based on observations at the group home, interviews with staff and residents, and the review of records including incident reports. | I 000 | | |
| I 160 | 3507.1 POLICIES AND PROCEDURES<br><br>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 provide guidance to each staff member.<br><br>This Statute is not met as evidenced by: Based on observation and staff interview on 3/13/2007, the Group Home for Mental Retardation (GHMRP) failed to ensure that policies and procedures were drafted to address a systemic breakdown in ensuring the security of medications during med-pass. [Residents #2, #4]<br><br>The finding includes:<br><br>During observations of the med-pass on 3/13/2007 the GHMRP failed to ensure the security of medications during the evening med-pass for two of six clients residing in the facility. There was no policy and procedure manual available for review at the time of survey to ensure compliance with this section and to assess the facility ' s proposed management of the observed deficient practice. [Reference Federal Deficiency Report Citation: W382-483,460(I)(2)] | I 160 | **1160**<br>**A policy and review manual regarding medication protocols and administration has been made available at the facility. Reference Federal deficiency 382-483, 460 (1)(2), the facility RN will in-service Trained Medication Employees (TMEs) quarterly on medication administration protocols as specified by the Department of Health guidelines, District of Columbia. 04/18/07** | |

Health Regulation Administration

Mattie [signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Vice President

(X6) DATE: 4/19/07

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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 |
|---|---|---|---|
| | 09G148 | | 03/15/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WHOLISTIC 03 | 1814 BUNKER HILL ROAD, NE<br>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 |
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| I 162 | 3507.3 POLICIES AND PROCEDURES<br><br>The manual shall be available for review and approval by District of Columbia personnel who have licensing, supervisory, monitoring and certification responsibility.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview and record review on 3/14/2007, the Group Home for Mental Retardation (GHMRP) failed to present the policies and procedures manual for review.<br><br>The finding includes:<br><br>The facility was found to be non-compliant in the areas of Client Protections, Facility Staffing and Active Treatment as found during the annual Federal recertification conducted on 3/13/2007 and presented in the Federal Deficiency Report drafted on 3/14/2007. There was no means available to the survey team at the time of survey to substantiate the GHMRP ' s written process for managing client care as found in the observed deficient practices. The facility failed to present its Policy and Procedures manual and as such was found to be out of compliance with this section. [Reference Federal Deficiency Report Citation: W122 - 483.420, W158 - 483.430, W195- 483.440] | I 162 | **1162**<br>**The facility's policy and procedures manual was made available to one of the two surveyors during the survey.**<br>**04/18/07** | |
| I 220 | 3510.1 STAFF TRAINING<br><br>Each employee who has no previous experience working with individuals with mental retardation shall be required to successfully complete orientation training appropriate to the needs of the residents in the GHMRP.<br><br>This Statute is not met as evidenced by: | I 220 | | |

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| I 220 | Continued From page 2<br><br>Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received training to ensure the health and well-being of its residents. [Residents #1, #2, #3, #4, #5, #6]<br><br>The finding includes:<br><br>During afternoon observations on 3/13/2007, the attending nurse was interviewed and she indicated that she had no prior experience working with the Mentally Retarded population prior to working within the current Group Home for Mentally Retarded Persons (GHMRP). Record review on 3/14/2007 revealed that she did not receive any training to this effect. | I 220 | **1220**<br>**On 04/09/07, all staff were in-serviced in areas such as: behavior support plans, privacy, dignity and respect, 2-person lifting and transfer, implementation of active treatment, overview of mental retardation, etc.**<br><br>**The QMRP will ensure that once a new Direct Care Staff or a Licensed Practical Nurse is hired, he/she will be provided with the necessary in-service/orientation prior to working with residents at this facility.**<br>**04/18/07** | |
| I 223 | 3510.4 STAFF TRAINING<br><br>Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that all training documentation included the required agenda for each training session.<br><br>The finding includes:<br><br>During record review on 3/14/2007 the staff training records was reviewed to assess the GHMRP ' s level of compliance with this section. Several of the documents presented were missing the proper and necessary inclusion of the written agendas detailing the content of the each training session. The QMRP indicated that the agendas in question were at the main office and | I 223 | **1223**<br>**At no point in time during the survey did the QMRP inform the survey team that the agendas for the trainings were kept in the office. The QMRP did inform the surveyors that incident investigation reports were kept in the office not the agendas.**<br><br>**In the future, the facility will ensure that all trainings are supported by detailed agendas.**<br>**04/18/07** | |

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| I 223 | Continued From page 3<br><br>may have been filed separately from what was presented during survey [Interview at 2:56pm on 3/14/2007]. | I 223 | | |
| I 224 | 3510.5(a) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills;<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received effective training on the health and well-being requirements of caring for the mentally retarded. [Residents #1, #2, #3, #4, #5, #6]<br><br>The finding includes:<br><br>Record review revealed that none of the new staff hired over the past certification year received training specific to the overview of mental retardation and its corresponding service needs to ensure the health and well-being of its residents. | I 224 | **1224**<br>**On 04/09/07, all staff were in-serviced in areas such as: behavior support plans, privacy dignity and respect, 2-person lifting and transfer, implementation of active treatment, and overview of mental retardation.**<br><br>**The QMRP will ensure that once a new Direct Care Staff or a Licensed Practical Nurse is hired, he/she will be provided with the necessary in-service/orientation prior to working with residents at this facility.**<br>**04/18/07** | |
| I 260 | 3512.1 RECORDKEEPING: GENERAL PROVISIONS<br><br>Each Residence Director shall maintain current and accurate records and reports as required by this section. | I 260 | | |

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| I 260 | Continued From page 4<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the GHRMP failed to ensure that data collected and filed in client records were maintained in an accurate manner to reflect current indicators of performance against the requirements of their behavior management plans for two of the three sampled residents.<br><br>The findings include:<br><br>1. Record review on 3/14/2007 revealed that the facility failed to ensure the accurate data collection of Resident #1 ' s maladaptive behaviors of " wrist biting, skin picking and scratching " as prescribed in her behavior support plan. [Reference Federal Deficiency Report Citation: W252 - 483.440(e)(1)]<br><br>2. Record review on 3/14/2007 revealed that the facility failed to ensure the accurate data collection of Resident #1 ' s maladaptive behavior of spitting " at or on people " as prescribed in her behavior support plan. [Reference Federal Deficiency Report Citation: W252 - 483.440(e)(1)]<br><br>3. Record review on 3/14/2007 revealed the facility failed to ensure the accurate record keeping of staff trainings. [Reference Licensure Report Citation: 3510.4] | I 260 | **1260, 1,2**<br>**Staff have been in-serviced on the behavior support plans for client #1 and client# 2. The psychologist will, on a quarterly basis in-service staff on proactive measures, interventions to behavior management, documentation of behavior episodes. The House manager will, on a weekly basis monitor staff to ensure compliance.**<br>**04/18/07**<br><br>**1260, 3**<br>**All staff training records are kept at the facility. Please refer to 1223.**<br>**04/18/07** | |
| I 261 | 3512.2 RECORDKEEPING: GENERAL PROVISIONS<br><br>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. | I 261 | | |

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| I 261 | Continued From page 5<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that the policy and procedure manual was managed as required by this section.<br><br>The finding includes:<br><br>The facility was found to be non-compliant in the areas of Client Protections, Facility Staffing and Active Treatment as found during the annual Federal recertification conducted on 3/13/2007 and presented in the Federal Deficiency Report drafted on 3/14/2007. There was no means available to the survey team at the time of survey to substantiate the GHMRP ' s written process for managing client care as found in the observed deficient practices. The facility failed to manage its Policy and Procedures manual as required by this section. [Reference Licensure Deficiency Citation: 3507.3] [Reference Federal Deficiency Report Citation: W122 - 483.420, W158 - 483.430, W195 - 483.440] | I 261 | **1261**<br>**The facility's policy and procedures manual was made available to one of the two surveyors during the survey.**<br><br>**Staff have been in-serviced on issues pertaining to management of the policy and procedure manual. Staff will be in-serviced semi-annually on Wholistic's policy and procedures.**<br>**04/18/07** | |
| I 422 | 3521.3 HABILITATION AND TRAINING<br><br>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that two of its six residents received the proper treatment interventions as outlined in their Behavior Support Plans. [Residents #1, #2]<br><br>The finding includes: | I 422 | | |

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| I 422 | Continued From page 6<br><br>During observations of client care on 3/13/2007 the facility failed to implement the proper proactive strategies to manage Resident #1 ' s maladaptive behaviors of skin picking, wrist biting, and scratching as prescribed in her behavior support plan. The facility also failed to implement the prescribed measures in managing Resident #2 ' s spitting " at or on people " as outlined in her behavior support plan. [Reference Federal Deficiency Report Citation: W249 - 483.440(d)(1)] | I 422 | **1422**<br>**Staff have been in-serviced on the behavior support plans for client #1 and client# 2. The psychologist will, on a quarterly basis in-service staff on proactive measures, interventions to behavior management, and documentation of behavior episodes. The House manager will, on a weekly basis monitor data collection and documentation to ensure compliance.**<br>**04/18/07** | |
| I 500 | 3523.1 RESIDENT'S RIGHTS<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that two of its six residents received the proper treatment interventions as outlined in their Behavior Support Plans. [Residents #1, #2]<br><br>The finding includes:<br><br>During observations of client care on 3/13/2007 the facility failed to implement the proper proactive strategies to manage Resident #1 ' s maladaptive behaviors of skin picking, wrist biting, and scratching as prescribed in her behavior support plan. The facility also failed to implement the prescribed measures in managing Resident #2 ' s spitting " at or on people " as outlined in her behavior support plan. [Reference | I 500 | **1500**<br>**Staff have been in-serviced on the behavior support plans for client #1 and client# 2. The psychologist will, on a quarterly basis in-service staff on proactive measures, interventions to behavior management, and documentation of behavior episodes. The House manager will, on a weekly basis monitor data collection and documentation to ensure compliance.**<br>**04/18/07** | |

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| I 500 | Continued From page 7<br><br>Federal Deficiency Report Citation: W249 - 483.440(d)(1)] | I 500 | | |