STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD 12-007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 03/27/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1449 ROXANNA ROAD NW WASHINGTON, DC 20012		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 000}	INITIAL COMMENTS A re-visit was conducted from March 26, 2008 to March 27, 2008. The purpose of the visit was to determine if the GHMRP had abated the deficiencies cited during the January 16, 2008 licensure survey, and to verify compliance with the plan of correction submitted to this office as a result of that survey. At the time of the re-visit, Resident #1 (who was admitted to the hospital on January 10, 2008) remained in the hospital. According to the Qualified mental Retardation Professional and verified by documents from The Department for Disability Services (DDS), the Resident was in need of palliative care and will not be returning to the facility. Resident #2 was admitted to the hospital on January 9, 2008 for wound care treatment. He was discharged back to the facility on March 13, 2008, and was receiving 24 hour nursing care. Resident #3 was not in the facility at the time of the revisit. He admitted to the hospital on March 11, 2008 for an abnormal Ph level, increased respirations and fever. His medical and habilitation records were reviewed. The findings of the re-visit survey were based on observations in the group home, interviews with the nursing and administrative staff in the home, as well as a review of all available resident and administrative records, including incident reports, and agency's policies.	{I 000}	RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2008 MAY -9 P 2:36	
{I 180}	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the	{I 180}		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matte Hons

TITLE: Vice President

(X6) DATE: 5/5/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD 12-007	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED R 03/27/2008
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{I 180}	Continued From page 1	{I 180}		
	needs of the residents as required by their Habilitation plans.			
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs for two of three residents in the sample as required by their habilitation plans. (Residents #2 and # 4)			
	The finding includes:			
	1. At the time of the initial visit, there was no documented evidence that Resident # 4 had received an audiology evaluation. Review of the resident's records on March 26, 2008 failed to show evidence that the client had been evaluated by an audiologist. Interview with the facility's Registered Nurse (RN) on the same day revealed that he had not been evaluated by the aforementioned specialist. It should be noted that the RN indicated that there is a scheduled appointment for April 9, 2008, However at the time of the revisit, there was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the audiology needs of the resident as required by his habilitation plan.		Audiologist completed appt.on April 9th 2008	04/09/08
	2. Review of Resident #2's Physician's Orders (PO) on March 20, 2008 a nebulizer machine for nebulizing breathing treatment was prescribed. Review of Resident #2's MAR revealed that the order for Albuterol nubulizer inhailation via mask was not implemented until March 23, 2008. Intervuiew with the RN revealed that she was not aware that the client would need a nebulizer for his breathing treatments. There was no evidence that the GHMRP ensured adequate		Neighborcare (pharmacy) was unable to deliver nebulizer equipment until the 23rd of March because it was not in stock. Provider will document all efforts and make records available to monitors.	04/27/08

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{I 180}	Continued From page 2 administrative support had been provided to ensure the procurement of the necessary equipment needed to administer breathing treatments as ordered.	{I 180}		
{I 391}	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of licensed professional staff secured by the group home to monitor interventions, in accordance with the needs of every individual for two of four residents in the sample. (Residents #2 and Resident #4) The findings include: 1. On March 26, 2008, at approximately 9:00 AM, the night Licensed Practical Nurse (LPN) indicated that Resident #2 was released from the hospital on March 13, 2008. The resident was observed in the facility in a wheelchair. He had a dressing on his right foot. Further interview with the LPN revealed that the resident had decubitus ulcers to multiple areas of his lower body.	{I 391}		

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{I 391}	Continued From page 3	{I 391}		
	Review of the physician's orders dated March 13, 2008, revealed orders for medications and dietary supplements. The orders did not contain the resident's diagnosis, wound care regimen i.e. turning and positioning, dressing changes etc. and the change in the resident ' s diet that was recommended by the nutritionist. In addition, the orders had not been signed by the primary care physician (PCP).			
	Interview with the facility's Registered Nurse (RN) on the same day at approximately 12:30 PM revealed that the orders reflected the recommendations by the physician that cared for the Resident #2 at the rehabilitation hospital and had not been endorsed by the PCP. When asked if the PCP was aware of the orders and was aware of the lack of complete orders (i.e. no diagnosis, no wound care instructions, no posistioning instructions, etc.), the RN indicated that the GHMRP was following the orders of the physician at the rehabilitation hospital. When asked to see the policy regarding the signing of orders, there was none presented nor was one observed in the policy manual.			
	At the time of the revisit, the GHMRP failed to ensure physician's orders were complete with all relevant resident information and care instructions.		POS for resident #2 has to be completed with all relevant information and care instructions.	03/27/08
	It should be noted that on March 26, 2007, the surveyor was presented with complete physician orders for Resident #2.			
	2. At the time of the initial visit, there was no documented evidence that Resident # 4 had received an audiology evaluation. Review of the resident's records on March 26, 2008 failed to		Audiology evaluation completed on 04/09/08.	04/09/08

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{I 391}	Continued From page 4 show evidence that the client had been evaluated by an audiologist. Interview with the facility's Registered Nurse (RN) on the same day revealed that he had not been evaluated by the aforementioned specialist. It should be noted that the RN indicated that there is a scheduled appointment for April 9, 2008, However at the time of the revisit, there was no documented evidence that the GHMRP ensured adequate administrative support had been provided to efficiently meet the audiology needs of the resident as required by his habilitation plan.	{I 391}		
{I 395}	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team for one of three residents in the sample. (Resident #3)	{I 395}		

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{I 395}	Continued From page 5 The findings include: During the initial survey, conducted in January 2008, it was noted that the nursing staff were not consistently recording on the wound care document the size and depth of open wounds weekly . Review of the wound care document for the month of March 2008 revealed several dates that did not contain the required wound measurments. The document was reviewed with the GHMRP's RN who acknowledeged that the Stage III wound on the right buttocks was not consistently measured according to the wound protocol. There was no documented evidence that the Stage III wound on the right buttocks was measured according to the wound protocol.	{I 395}	RN will now do all measurements regarding wound care/ protocols. RN will measure weekly. Protocol has been amended to reflect change.	04/21/08
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP s nursing services failed to ensure medications were administered as ordered for one of the three residents in the sample (#2), failed to ensure laboratory specimens were collected as ordered for one of the three residents in the sample (#2), and failed to ensure the procurement of the necessary medical equipment needed for resident care for one of three residents in the sample (#2).	{I 401}	See 3521.1 3520.0	

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{I 401}	Continued From page 6	{I 401}		
	The findings include:			
	1. Review of Resident #2's Physician's Orders (PO's) dated March 13, 2008 on March 26, 2008 at 9:30 AM revealed an order for Mucomyst nebulizer inhalation via mask two times daily for treatment of chest congestion as needed. Review of the medication administration record on the same day failed to reflect that the order was transcribed. The medication cabinet was inspected and revealed that the medication was not in the facility. The Licensed practical nurse on duty acknowledged that the medication was not in the facility and that the Resident had not received the medication. Interview with the Registered Nurse on the same day revealed that the physician from the rehabilitation hospital discontinued the medication; however, there was not order in the record to support the RN's statement. At the time of the re-visit, there was no documented evidence that an order had been implemented as written for Resident #2. It should be be noted that on March 27, 2008, the surveyor requested a copy of the orders. A notation was added to the orders to reflect that the order was discontinued on March 18, 2007. The chart still did not reflect an official order to discontinue the medication.		The order for nebulizer has been discontinued.	03/28/08
	2. Review of Resident #2's POs on March 26, 2008 at 11:30 AM revealed an order for three stool specimens to be collected and sent to the lab for the detection of C-difficile. Review of the laboratory results and verified by the RN on March 27, 2008 at 1:30 PM revealed that the stool specimens had not been collected as ordered.		Stool specimens have been collected as ordered and sent to lab on 04/01/08, 03/28/08 and 04/08/08	04/27/08

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{I 420}	Continued From page 7	{I 420}		
{I 420}	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning for one of three residents in the sample. (Resident #4) The finding includes: During the initial survey in January 2008, it was discovered that Resident #4's Psychologist's assessment dated September 15, 2007 reflected a recommendation requesting that the Psychiatrist rule out the Axis I diagnosis of Schizophrenia due to the absence of psychiatric symptoms for a long period of time and that the resident is not on any psycotropic medications. Review of the Plan of Correction (POC) dated February 15, 2008 revealed that the resident was scheduled to see the Psychiatrist on March 12, 2008 to address the psychologist's recommendation. Review of the record on March 27, 2008 at 1:30PM failed to show evidence that the resident had been re-evaluated by the spychiatrist as stated in the POC. In an interview with the QMRP on March 27, 2008 at 2:30 PM, he indicated that the client had been evaluated by the spychiatrist, however the documentation was	{I 420}	Resident #4 has been evaluated by psychiatrist. Please find docu- mentation attached.	04/28/08

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{I 420}	Continued From page 8 not available for review. At the time of the re-visit, there was no documented evidence that the Psychologist's recommendation was addressed by the IDT.	{I 420}		
{I 473}	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that any irregularities in the drug regimen for two of three residents in the sample was reported to the primary care physician (PCP). (Resident #2 and Resident #4) The findings include: 1. Review of Resident #2's, physician's orders (POS) dated March 13, 2008 on March 26, 2008 at approximately 10:30 AM revealed an order for mucomyst nebulizer inhailation via mask 2 times daily for treament of chest congestion.as needed. review of the medication administration record (MAR) on the same day revealed the order had not been transcribed. The medication was not in the medication cabinet upon inspection. Interview with the facility's Registered Nurse on the same day at 12:30 PM revealed that the ordering physician discontinued the medication and therefore the medication was not given. Review of the POS failed to show evidence that the order had been discontinued as the RN stated. Further review of the record failed to show evidence that the PCP was aware of the orders. The GHMRP failed to adminster medications as ordered.	{I 473}	All medication irregularities in drug regimen shall be forwarded to prescribing physician. Physician monthlies shall discuss medication irregularities.	

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{I 473}	Continued From page 9 2. Review of Resident #4's, medical record revealed that the resident was an in patient at a long term care facility prior to his admission to the GHMRP. The resident was evaluated by the GI specialist on September 2, 2007. At that time, it was recommended that the client's Pepcid be changed to Nexium. The Nexium order was changed on September 10, 2007 to Prevacid 30mg. The medication was initiated at that time. Review of the residents medication administration record (MAR) on March 27, 2008 at 2:30 PM revealed that the resident is prescribed Pepcid and Prevacid. Review of the Pharmacy review in December 2007 revealed a recommendation to the physician to evaluate the need for the pepcid and prevacid. Review of the MARs for December 2007 to March 2008 revealed that the resident remains on both medications. The RN was asked if the primary care physician was aware of the recommendation from the pharmacist. She was not aware if the PCP had been made aware of the recommendation. At the time of the re-visit, there was no evidence that recommendations made by the pharmacist was relayed to the PCP for consideration.	{I 473}	Physician notified of and received verbal order from PCP that Resident should remain on both Prevacid and Pepcid.	04/27/08

Wholistic Services, Inc.

Medical Consultation

Name: Louis Quetal
DOB: 12/28/45
Address: 1449 Roxanna Rd.
SS#: 578-92-1543
Type of Consultation: Audiology
Medicaid #: 701-26-227
Medicare #:
Phone Number: 202-877-6717
Primary MD: Dr. Ishmael Kalokoh
Date of Appt.: April 9th 9AM
Home Number: (202) 291-0123

Medications:

- Colace 10 ml via G-Tube QD
- Pepcid 20 mg via G-Tube BID
- Lovenox 40 mg SQ QD
- Lopressor 50 mg via G-Tube BID
- Multivitamin 1 tablet via G-tube QD
- Potassium Cholride – 30 ml via G-tube QD
- Prevacid 30 mg via G-Tube QD
- Zocor 20 mg via G-Tube QD

Reason for Referral:

Audiology eval.

Consultant's Notes:

See attached report
Thank you for returning this patient.

Washington
Hospital Center
MedStar Health

Refer to Interdisciplinary Problem List for updating the Plan of Care.
All Progress Notes should include problem, plan/goals, and patient response, outcome.

DATE & TIME	PROGRESS NOTES
	Hearing & Speech Center
	62 y/o OM Referred by Wholistic for Diagnostic Audiometric Evaluation
	History – Chief Complaint: ☒ Group Home Resident ☐ Verbal ☒ Non- Verbal
	Date of Last Evaluation: 1999 - records not available at this time.
	Hearing Loss: unknown status.
Abbreviation	OME/Ear Surgeries: ∅
Key:	Falls: uses wheelchair & walks only c̄ assistance.
ME =	Other Notes: ∅
Middle Ear	
MEP =	**Diagnostic Audiometric Evaluation**
Middle Ear	**Immittance:** Normal MEP & compliance bilaterally. CNT reflexes as
Pressure	seal could not be maintained.
HL =	
Hearing Loss	**Speech Awareness / Reception Thresholds:** WNL bilat (pt points to nose on command)
SN =	
Sensorineural	**Word Recognition Ability:** CNT - CNC
CHL =	
Conductive HL	**Hearing for Pure-Tones:** CNT - CNC
MHL =	
Mixed HL	
CNC=	
Could Not	**Otoacoustic Emissions:**
Condition	☐ N/A ☒ Present: Robustly 1-4KHz ©. OAES present @ 2-3KHz ® -
WNL =	☐ Absent: note poor probe fit & ↑ noise ↓ ability to test the ear
Within Normal	**Impressions:**
Limits	① Normal middle ear pressure & compliance bilaterally.
DNT =	② Present OAEs & NL SAT suggest hearing is adequate for
Did Not Test	communication.
CNT =	**Recommendations:** re-eval as needed.
Could Not Test	
NA =	
Not Applicable	

Clinical Audiologist

INTERDISCIPLINARY PLAN OF CARE PROGRESS NOTES

4/9/08
10:30 AM

Quetel, Louis
BN: 123765331
62M
12/28/1945
MRN: 2270648
0504
04/09/2008
09:54

FORM 205 83-2074-9 R04/05/04

Washington Hospital Center
MedStar Health

HEARING AND SPEECH CENTER
AUDIOLOGIC EVALUATION

WHC0028 1

Name QUETEL, LOUIS Referred by WHOLISTIC

WHC No. 227-06-48 Sex M Race CAUC Age 62 In-Pt. [ ] Out-Pt. [X]

Date 04-09-08 Time 09:44:11 Audiologist SUROWICZ CCC-A Audiometer GSI-61-2 ANSI 1969

LEFT EAR

Hz	250	500	1000	2000	3000	4000	6000	8000
AC	----	----	----	----	----	----	----	----
BC	----	----	----	----	----	----		

AS MASKED: BONE - dB AIR - dB

---% ---% ---% ---% ---%

WEBER

Hz Hz

STENGER

TYPE
AS dB AD dB
TYPE
AS dB AD dB

RIGHT EAR

Hz	250	500	1000	2000	3000	4000	6000	8000
AC	----	----	----	----	----	----	----	----
BC	----	----	----	----	----	----		

AS MASKED: BONE - dB AIR - dB

---% ---% ---% ---% ---%

HEARING FOR SPEECH - LEFT

SRT	PB SCORE	PB LEVEL	PBL#
* 12 dB	---- %	--- dB	----
	%	dB	
	%	dB	
	%	dB	

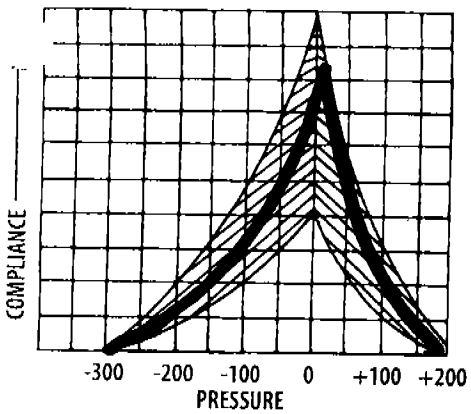
BINAURAL

	SRT	PB SCORE	PB LEVEL	PBL#
(ph)	dB	%	/ dB	
(sf)	dB	%	/ dB	

HEARING FOR SPEECH - RIGHT

SRT	PB SCORE	PB LEVEL	PBL#
* 12 dB	---- %	--- dB	----
	%	dB	
	%	dB	
	%	dB	

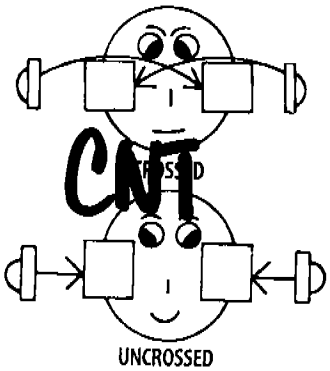
TYMPANOGRAM - LEFT



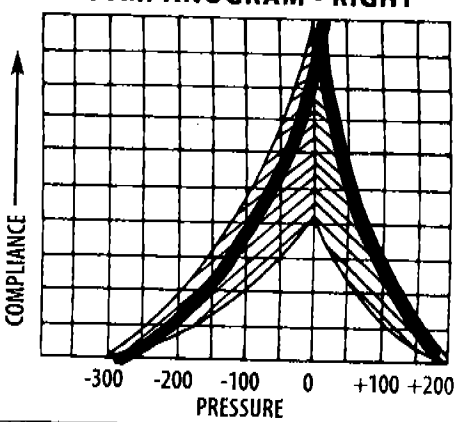
IMMITTANCE MEASURES

REFLEX PATTERN

☐ Normal
☒ Elevated
■ Absent



TYMPANOGRAM - RIGHT



EAR	TYMP	STAT COMPL.	MEP	STAPES REFLEX	500	1000	2000	STAPES REFLEX	500	1000	2000	REFLEX DECAY			
LEFT	A	WNL	12	CONTRA-LATERAL	----	----	----	IPSI-LATERAL	----	----	----	500	---	1000	---
RIGHT	A	WNL	12	CONTRA-LATERAL	----	----	----	IPSI-LATERAL	----	----	----	500	---	1000	---

SUMMARY

	AC AVG	BC AVG	SRT	PB MAX	PB ROLL	OAE	STENGER	REF DECAY
LEFT	---	---	*12	---	---	PRS	---	---
RIGHT	---	---	*12	---	---	PRS	---	---

COMMENTS: ---- = Did not test, Prs = Present, Abs = Absent, CNT = Could not test

*SAT ONLY - PT POINTED TO NOSE. CNC SRT, WORD REC OR PURE TONES EARSCAN USED TO OBTAIN SEAL FOR IMMITTANCE.

Print Date:

Physician's Order Form

Facility Name: wholistic Serviced

ALLERGIES: NKA

Medicaid #:

Medicare #:

Physician	Phone No.	Start Date	Pharmacy ID #
Kalokoh		4/1/08	

Resident Name	Med. Record No.	Nurse Station	Room No.	Birthday	Sex	Page No.
Quetel, Louis		Pavan		12/28/46	M	1 of 1

Generic Equivalent is authorized unless written **"Brand Medically Necessary"** opposite Drug Name

Date	Physician's Orders and Signature	Discontinued By: Date	Time	Initial
4/1/08	Continue c̄ both Prevacid and Pepcid d/t diverticular disease.			
	v/o per Dr. Kalokoh / transcribed by Margo, RN			
	-noted by Maheni Joh, RN			