



Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/11/2009
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1448 ROXANNA ROAD NW WASHINGTON, DC 20012
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I 227 Continued From page 1  
limited to, the following:

(d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans;

This Statute is not met as evidenced by:  
Based on record review, the facility failed to ensure that all staff received training and was certified to perform first aid and cardiopulmonary resuscitation (CPR) procedures.

The finding includes:

Record review on 2/11/2009 at approximately 12:11pm revealed two (2) out of twelve (12) direct care staff records reviewed were missing evidence of CPR certification [DCS #2, #5]. Further record review revealed two (2) out of the twelve (12) direct care staff records reviewed were also missing evidence of First Aid certifications [DCS #4, #6].

I 227

I 227, d  
Staff #2 & #5 have been scheduled to complete CPR training. Staff #4 & #6 have been scheduled to complete First Aid Training.

In the future, the facility shall conduct monthly audit of staff records so as to ensure compliance.

04/30/09

I 230 3510.5(g) STAFF TRAINING

Each training program shall include, but not be limited to, the following:

(g) Habilitation planning and implementation;

This Statute is not met as evidenced by:  
Based on record review, the facility failed to ensure that all staff received training on using Resident #1's Moyer Lift.

The finding includes:

Record review on 2/10/2009 at 3:58pm revealed,

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I 230	Continued From page 2  staff were trained on using a "Hoyer Lift Transfer" to manage the physical transport of Resident #1. Interview with the facility's QMRP on 2/10/2009 at 4:03pm revealed the training took place over the past year and that the training sheet presented was accurate. Further review of the document revealed, there was no evidence to support that three (3) of the seven (7) direct care staff received training on using the Hoyer Lift [DCS #2, #4, #6].  [Cross Reference Citation 3514.2]	I 230	I 230 The training of the use of the Hoyer lift was done over a year ago, and its use had been discontinued since July 2008. The three staff who did not receive the training had joined Wholistic staff after the use of the Hoyer lift was discontinued.  03/28/09	
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS  Each Residence Director shall maintain current and accurate records and reports as required by this section.  This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the upkeep and accuracy of each resident's behavioral data, for one resident in the investigation. (Resident #1)  Record review on 2/10/2009 at 3:35pm revealed, Resident #1's behavior support plan detailed, "[Resident #1] has a behavior goal to decrease episodes of attempting to or actually pulling out his g-tube to zero (0) incidents per month for twelve consecutive months." In addition, the plan requires the following interventions:  1. Hand mitts should be placed on Resident #1's hands if he makes any attempt at all to pull out his g-tube.  2. Hand mitts will be worn for two-hour increments and removed at the end of the	I 260		

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I 260 Continued From page 3

Two-hour period during waking hours only.

3. At night, the hand mitts must be worn while he is sleeping to prevent him from pulling out his g-tube.

Staff interviews on 2/10/2009 and again on 2/11/2009 revealed the use of the mitts for Resident #1's hands was a frequent occurrence. According to the information obtained through the interviews, Resident #1 would typically have his gloves on throughout the day in two hour increments. There was no evidence presented or on file to reflect that the above behavioral goal was being documented as required. In addition, the only data collected by the facility and presented during the investigation reflected that Resident #1 actually pulled out his G-Tube on 1/15/2008 and again on 1/15/2009. The facility failed to ensure current and accurate record keeping with regards to Resident #1's behavioral data.

I 260

I 260  
Staff were trained on the effective implementation of the Behavior Support Plan but failed to implement the proper procedures and documentation of behavior data.

At present, the facility does not have any individual who has a behavior support plan. However, in the future the facility House Manager (HM) shall on a weekly basis monitor the implementation of behavior interventions, data collection and record keeping.  
03/28/09

I 291 3514.2 RESIDENT RECORDS

Each record shall be kept current, dated, and signed by each individual who makes an entry.

This Statute is not met as evidenced by: Based on record review and staff interviews, the GHMRP failed to ensure that all documentation in Resident #1's records was kept current, dated and signed as required by this section.

The finding includes:

Record review on 2/10/2009 at 3:59pm revealed, staff were trained on using a "Hoyer Lift Transfer" to manage the physical transport of Resident #1. There was no evidence of a supporting signature

I 291

I 291  
This was an oversight. In the future, the Qualified Mental Retardation Professional (QMRP) and the facility's Registered Nurse (RN) will review all training records on a quarterly basis or as needed to ensure that such mistake is not repeated.  
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I 291	Continued From page 4  or date on the training sheet to validate the document. The facility failed to ensure the document was validated and/or dated to reflect that it was current as required by this section.	I 291		
I 379	<p><b>3519.10 EMERGENCIES</b></p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to notify the Department of Health of incidents that placed resident's at risk, for two of three residents that resided in the facility ( Resident #2, and #3).</p> <p>The finding includes:</p> <p>Resident #2 was involved in an allegation of staff abuse on 9/8/2007, and Resident #3 was also involved in an allegation of staff abuse on 1/27/2007. There was no evidence presented or on file at the facility during the survey to substantiate that the GHMRP made attempts to contact the Department of Health regarding these incidents.</p>	I 379	<p><b>I 379</b></p> <p>This was a misunderstanding as to the nature of the incident and the two residents involved. Resident #2 and #3 had never been involved in an allegation of abuse.</p> <p>The incidents of abuse involved two former residents of the facility who left the facility over a year ago. Department of Health was notified of the allegations of abuse in both instances.</p> <p style="text-align: right;">03/28/09</p>	

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1395	Continued From page 5	1395		
1396	<p><b>3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS</b></p> <p>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:</p> <p>(e) Nursing;</p> <p>This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team for one resident in the investigation. (Resident #1)</p> <p>The findings include:</p> <p>1. Review of Resident #1's physician orders (POS) dated January 2009 on February 10, 2009 at approximately 11:50 AM revealed the resident had a diagnosis that included a Stage IV right ischial decubitus ulcer. Review of Resident #1's Monthly Nursing Assessment dated September 11, 2008 on February 11, 2009 at approximately 10:02 AM revealed the Stage IV wound on the right ischial measured 6 cm in length and 2.6 cm in width with tunneling and necrosis. Review of the physician's orders (POS) dated January 2009,</p>	1396		

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I 395	<p>Continued From page 6</p> <p>on February 11, 2009 at approximately 9:07 AM revealed Resident #1 had an order for "1% Cream Silver Sulfadiazine (Silvadene) to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing". In an interview with the Licensed Practical Nurse (LPN) on February 11, 2009 at approximately 10:40 AM it was acknowledged that Resident #1's POS did not specify the specific wound site. There was no evidence the POS specified the specific site of the wound to be treated. Additionally, the nurse failed to clarify the order.</p> <p>2. Review of Resident #1's physician orders (POS) dated January 2009 on February 10, 2009 at approximately 11:50 AM revealed the resident had a diagnosis that included a Stage IV right ischial decubitus ulcer. Review of Resident #1's Monthly Nursing Assessment dated September 11, 2008 on February 11, 2009 at approximately 10:02 AM revealed the Stage IV wound on the right ischial measured 8 cm in length and 2.6 cm in width with tunneling and necrosis. Review of the undated document entitled "Pressure Ulcer Documentation Guidelines" for Resident #1 on February 11, 2009 at approximately 10:10 AM revealed a recommendation to measure and record the dimensions (length, width and depth) of pressure ulcers weekly. Review of Resident #1's Skin Assessment Sheets dated August 2008, October 2008 through January 19, 2009 on February 11, 2009 at approximately 10:15 AM revealed the Stage IV wound on the right ischial was not measured. Further review revealed there were no Skin Assessment Sheets dated for September, 2008. In an interview with the Registered Nurse (RN) on February 11, 2009, at approximately 10:20 AM it was acknowledged that the Stage IV wound on the right ischial, was not measured and recorded on the Skin</p>	I 395	<p>I 395, 1 The RN shall review all orders on a monthly basis or as needed to ensure that all treatment orders are clearly defined. Orders shall be clarified monthly and then specified on the POS and MAR.</p> <p style="text-align: right;">03/28/09</p>	
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I 395 Continued From page 7

Assessment Sheets. Further interview revealed the Skin Assessment Sheets for September 2008 could not be located. There was no documented evidence the Stage IV wound on the right ischial of Resident #1 was measured and recorded on the Skin Assessment Sheets according to the Pressure Ulcer Documentation Guidelines.

3. Review of Resident #1's, Skin Assessment Sheets dated August 1-11, 2008 on February 11, 2009 at approximately 11:04 AM revealed the Stage III wound on the right peri anal was not measured and recorded. In an interview with the RN on February 11, 2009, at approximately 11:05 AM it was acknowledged the Stage III wound on the right peri anal was not measured and recorded according to the Pressure Ulcer Documentation Guidelines. There was no documented evidence the Stage III peri anal wound was measured and recorded according to the Pressure Ulcer Documentation Guidelines.

4. In an interview with the RN on February 11, 2009, at approximately 10:22 AM it was revealed that Resident #1's Stage IV wound on the right ischial, was treated with 1% Cream Silver Sulfadiazine (Silvadene), applied to wound twice daily and gently packed with gauze and covered with a dry sterile dressing. Review of Resident #1's POS dated December 18, 2008, on February 10, 2009 at approximately 11:59 AM revealed an order for Silvadene to be applied to the wound twice daily and to gently pack with gauze and cover with a dry sterile dressing. Review of the August POS dated July 29, 2008 on February 23, 2009 at approximately 9:00 AM revealed wet to dry dressings to the ischial wound were discontinued on June 23, 2008. Review of Resident #1's, Skin Assessment Sheets dated August 2008 and October 2008 through January

I 395

I 395, 2 & 3

The nursing staff have been in-serviced on adhering to orders as written. The RN will on a monthly basis review all orders or guidelines with the nursing staff so as to ensure compliance.

Documentation records such as skin assessment sheets, pressure ulcer documentation sheets, etc. shall be tracked monthly by the RN to ensure that records are maintained on a consistent monthly basis.

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I 395, 4

Cross reference I 395, 2&3.

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I 395	Continued From page 8  19, 2009 on February 23, 2009 at approximately 9:20 AM revealed a wet to dry dressing was applied to the Stage IV wound on the right ischial. There was no documented evidence that the Stage IV wound on the right ischial was gently packed with gauze and covered with a dry sterile dressing.  5. Review of Resident #1's POS dated December 2008 on February 23, 2009 at approximately 1:09 PM revealed an order for Xenaderm ointment to be applied to sacral wound twice daily. Review of Resident #1's, Skin Assessment Sheets dated December 1-31, 2008 on February 23, 2009 at approximately 1:15 PM revealed Xenaderm ointment was applied to the sacral wound and the wound was covered with a wet to dry dressing. There was no documented evidence that the sacral wound was treated specifically as ordered by the Primary Care Physician (PCP).  6. Review of Resident #1's August POS dated July 29, 2008, on February 10, 2009 at approximately 11:59 AM revealed an order for Silvadene to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing. Review of Resident #1's, Skin Assessment Sheets dated August 2008 on February 23, 2009 at approximately 9:00 AM revealed Panafil ointment was applied to the Stage IV wound on the right ischial and covered with a wet to dry dressing. There was no documented evidence that the Stage IV wound on the right ischial was treated with Silvadene cream as ordered by the PCP.  7. Review of a nursing progress note dated January 15, 2009 on March 8, 2009 at approximately 8:15 PM revealed Resident #1 was	I 395	I 395, 5 & 6 Cross reference I 395, 2 & 3. 03/28/09	

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1395	<p>Continued From page 9</p> <p>transported to the emergency room department after pulling out his gastric tube. Review of the hospital discharge summary dated January 17, 2009 on March 6, 2009 at approximately 6:16 PM revealed the facility was given instructions for the client to be assessed by the gastroenterologist within one to two days. Interview with the RN on February 10, 2009 at approximately 11:15 AM revealed the earliest appointment that the facility could obtain from the gastroenterologist was on February 2, 2009. There was no evidence the resident was followed up by a gastroenterologist with-in one to two days after his gastric tube was replaced with a temporary catheter.</p> <p>8. Review of Resident #1's physician orders (POS) dated January 2009 on February 10, 2009 at approximately 11:50 AM revealed the resident had a diagnosis that included a Stage IV right ischial decubitus ulcer. Review of Resident #1's wound clinic consultation dated August 8, 2008 on March 5, 2009 at approximately 6:19 PM revealed the resident had a Stage IV right ischial decubitus ulcer with tunneling 7 cm x 12 degrees and a right perianal area 2 cm times 1 cm. There was no documented evidence the resident was assessed in the wound clinic after August 8, 2008.</p> <p>8. Review of Resident #1's POS dated December 2008 and January 2009 on March 9, 2009 at approximately 6:22 PM revealed that the resident has a diagnosis of seizure disorder and was prescribed Keppra 7.5ml (750 mg) via gastric tube twice a day and Valproic Acid 12 ml (600 mg) via gastric tube twice a day for seizure management. Review of a neurology consult dated October 26, 2008 on March 9, 2009 at approximately 6:23 PM revealed the resident was</p>	1395	<p><b>I 395, 7</b></p> <p>This is one of the systemic problems faced by residential facilities. The facility was not able to find a gastroenterologist who was able to see resident #1 within one to two days as ordered. The earliest available appointment was February 2, 2009.</p> <p>However, two days after resident #1 was discharged home, he was again taken to a hospital for further medical attention.</p> <p style="text-align: right;">03/28/09</p> <hr/> <p><b>I 395, 8</b></p> <p>There was no recommendation for resident #1 to return to the wound clinic before six months. However, the facility had booked an appointment with the wound clinic for February 9<sup>th</sup>, 2009. Unfortunately resident #1 expired on February 6<sup>th</sup>, 2009.</p> <p style="text-align: right;">03/28/09</p>	

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1395	Continued From page 10 to return to the neurology clinic in one month. There was no documented evidence that Resident #1 returned to the neurology clinic or was scheduled for a neurology appointment.	1395	<div style="border: 1px solid black; padding: 5px;"> <p>I 395, 9 The QMRP and the RN will on a monthly basis review all medical records to ensure that appointments and recommendations are followed up and in a timely manner.</p> <p style="text-align: right;">03/28/09</p> </div>	
1401	<p><b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interview and record review the QMRP failed to provide professional services that included both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident, for one of one resident in the investigation. (Resident #1)</p> <p>The findings include:</p> <p>1. Review of Resident #1's physician orders (POS) dated January 2009 on February 10, 2009 at approximately 11:55 AM revealed an order for the resident to receive enteral feedings of Isosource 1.5, six cans daily to meet his nutritional needs</p> <p>Review of Resident #1's nutritional assessment dated October 20, 2008 on February 10, 2009 at approximately 12:00 PM also confirmed the diet through the nutritionist's recommendations.</p> <p>Review of Resident #1's Health Management</p>	1401		

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I 401	<p>Continued From page 11</p> <p>Care Plan (HMCP) dated May 3, 2008 and revised on January 2, 2009 on February 10, 2009 at approximately 12:05 PM indicated "monitor diet and encourage consumption of food high in fiber and bulk".</p> <p>In an interview with the Registered Nurse (RN) on February 10, 2009 at approximately 12:06 PM it was acknowledged that the HMCP had not been updated to include isosource 1.5, six bolus cans daily to meet his nutritional needs.</p> <p>There was no documented evidence that the HMCP had been updated after January 2, 2009 to include isosource 1.5 six bolus cans to meet his nutritional needs.</p> <p>2. Review of a nursing progress note dated January 17, 2009 on February 10, 2009 at approximately 12:06 PM revealed Resident #1 was transported to the emergency room after having loose stools. Review of the hospital discharge summary dated January 17, 2009 on February 10, 2009 at approximately 12:07 PM revealed Resident #1 was diagnosed with diarrhea and hypertension and released to the group home.</p> <p>Review of Resident #1's HMCP dated May 3, 2008 and revised on January 2, 2009 on February 10, 2009 at approximately 12:07 PM indicated "monitor bowel movement and stool consistency and record...".</p> <p>Review of Resident #1's nursing progress notes dated January 18, 2009 between the hours of 8:00 PM and 8:00 AM on February 10, 2009 at approximately 12:18 PM revealed the resident "had loose stools times two, amount 500cc and 500cc during the night".</p>	I 401	<p>I 401, 1</p> <p>The HMCP was updated but failed to specify the exact form of the diet order. In the future, the RN shall include in the HMCP recommendations or orders as specified.</p> <p>The QMRP and the RN will on a monthly basis review all areas of the HMCP to ensure that orders and/or recommendations are included on the HMCP as specified.</p> <p style="text-align: right;">03/28/09</p>	

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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC HOME & COMMUNITY BASED SE		STREET ADDRESS, CITY, STATE, ZIP CODE 1448 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
1401	Continued From page 12  Review of Resident #1's Input and Output Chart dated January 19, 2009 on February 10, 2009 at approximately 12:20 PM indicated "see notes" at 8:00 AM. Further review revealed the amount of the loose stools expelled by the resident was not documented on the Input and Output Chart.  Review of Resident #1's nursing progress notes dated January 20, 2009 between the hours of 8:00 AM and 8:00 PM on February 10, 2009 at approximately 12:19 PM revealed "that at approximately 7:30 AM about 200cc watery loose stools observed" and approximately 150cc of watery stool was observed in the colostomy bag at about 1:00 PM. Further review revealed at approximately 3:30PM, 500cc of watery stool was observed in the colostomy bag on the same day.  Review of Resident #1's Input and Output Chart dated January 20, 2009 at 6:00 AM on February 10, 2009 at approximately 12:22 PM indicated "see notes" Further review revealed the amount of the loose stools expelled by the resident was not documented on the Input and Output Chart.  In an interview with the RN on February 10, 2009 at approximately 12:25 PM it was acknowledged the amount of loose stools expelled by Resident #1 was not documented on the Input and Output Chart.  There was no documented evidence the amount of loose stools expelled by the resident was documented consistently on the Input and Output Chart.  3. Review of Resident #1's POS dated December 2008 and January 2009 on February 10, 2009 at approximately 11:57 AM revealed an	1401	I 401, 2 The nursing staff have been trained to document on the specified form a required task. The writing of "see notes" shall not be used in place of a required data collection.  The RN will on a monthly basis review charts/sheets to ensure that data are collected as specified.  03/28/09	

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I 401	<p>Continued From page 13</p> <p>order to "flush with 166 cc of water before and after each feeding via gastric tube".</p> <p>Review of Resident #1's HMCP dated May 3, 2008 and revised on January 2, 2009 on February 10, 2009 at approximately 12:08 PM indicated "flush tubing with 100 ml. of water before and after each bolus feeding".</p> <p>In an interview with the RN on February 10, 2009 at approximately 12:30 PM it was acknowledged the HMCP had not been updated to include the resident's gastric tube flushing with 166 cc of water before and after each feeding.</p> <p>There was no documented evidence the HMCP had been updated after January 2, 2009 to include the resident's gastric tube flushing with 166 cc of water before and after each feeding.</p> <p>4. Review of Resident #1's POS dated January, 2009 on February 10, 2009 at approximately 11:58 AM revealed an order to "flush with 30cc of water before and after each medication pass".</p> <p>Review of Resident #1's HMCP dated May 3, 2008 and revised on January 2, 2009 on February 10, 2009 at approximately 12:08 PM indicated "flush tubing with 30 milliliters (ml) of water after each medication".</p> <p>In an interview with the RN on February 10, 2009 at approximately 12:35 PM it was acknowledged that the HMCP had not been updated to include flushing the gastric tube with 30 ml. of water before and after each medication.</p> <p>There was no documented evidence the HMCP had been updated after January 2, 2009 to include flushing the gastric tube with 30 ml. of</p>	I 401	<p>I 401:3, 4, 5 &amp; 6 Cross reference I 401, 1. 03/28/09</p>	

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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC HOME & COMMUNITY BASED SE		STREET ADDRESS, CITY, STATE, ZIP CODE 1448 ROXANNA ROAD NW WASHINGTON, DC 20012		
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1401	Continued From page 14 water before and after each medication.  5. Review of Resident #1's POS dated December 18, 2009 and January 2009 on February 10, 2009 at approximately 11:59 AM revealed an order for 1% Cream Silver Sulfadiazine (Silvadene) to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing. Review of Resident #1's HMCP dated May 3, 2008 and revised on January 2, 2009 on February 10, 2009 at approximately 12:09 PM revealed that the HMCP had not been updated to include the resident's specific wound management protocol. There was no documented evidence that the HMCP had been updated to include the resident's specific wound management protocol.  6. Review of Resident #1's hospital transfer summary dated July 18, 2008 on February 24, 2009 at approximately 10:50 AM revealed the resident had been admitted to the hospital for a Urinary Tract Infection (UTI) on July 10, 2008. Further review revealed "please do not place Foley catheter, use only Texas Catheter to prevent recurrent UTI". Review of Resident #1's POS dated August 21, 2008 on February 24, 2009 at approximately 10:59 AM revealed an order for a Texas Catheter to prevent UTI. Review of Resident #1's Individual Support Plan (ISP) dated October 29, 2008 [Effective date November 29, 2008] on February 24, 2009 at approximately 11:00 AM revealed a Texas Catheter was documented under assistive technology. Review of Resident #1's HMCP revised January 2, 2009 on February 24, 2009 at approximately 12:36 PM revealed the HMCP stated "change incontinence briefs every two hours and as needed". There was no documented evidence that the HMCP had been	1401		

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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 401	Continued From page 15 updated to include the application of a Texas Catheter to prevent UTI.  7. Review of Resident #1's POS dated December 16, 2008, on February 11, 2009 at approximately 2:55 PM revealed an order for 1% Cream Silver Sulfadiazine (Silvadene) to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing. Review of Resident #1's Medication Administration Records (MAR's) dated August 2008 at approximately 3:00 PM revealed that the order for Silvadene to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing contained a notation to "see skin assessment sheet". Review of Resident #1's MAR dated September 2008 at approximately 3:02 PM revealed the order for Silvadene to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing was transcribed but contained no data. There was no documented evidence 1% Cream Silver Sulfadiazine to be applied to wound twice daily and to gently pack with gauze and cover with a dry sterile dressing had been documented on the August and September 2008 MARs.  8. Review of a nursing progress note dated January 17, 2009 on February 10, 2009 at approximately 12:06 PM revealed Resident #1 was transported to the emergency room after having loose stools. Review of the hospital discharge summary dated January 17, 2009 on February 10, 2009 at approximately 12:08 PM revealed Resident #1 was diagnosed with diarrhea and released to the group home with instructions to "use over the counter anti-diarrheal agents of your preference". Review of Resident #1's telephone POS dated January 17, 2009 on	I 401	I 401, 7 The RN has in-serviced the LPNs on accurate data collection (please see evidence herewith). Nurses will be trained quarterly on accurate and consistent data collection.  03/28/09	

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I 401	<p>Continued From page 18</p> <p>February 10, 2009 at approximately 12:11 PM revealed an order for Imodium 2 mg via peg tube after each loose stool (1mg/7.5 ml ) 15 ml. Review of the MAR dated January 2009 on February 10, 2009 at approximately 1:54 PM revealed that Imodium 2mg via peg tube was administered on January 17, 2009 and January 18, 2009. However the time the medication was administered was not documented on the MAR. In an interview with the Licensed Practical Nurse (LPN) it was acknowledged that the time Imodium 2 mg via gastric tube was administered was not documented on the MAR. There was no documented evidence of the time Imodium 2 mg via gastric tube was administered on January 17, 2009 and January 18, 2009.</p> <p>9. Review of Resident #1's telephone POS dated January 17, 2009 on February 10, 2009 at approximately 12:11 PM revealed an order for Imodium 2 mg via peg tube after each loose stool (1mg/7.5 ml ) 15 ml. Review of Resident #1's nursing progress notes dated January 18-20, 2009 on March 6, 2009 at approximately 5:23 PM revealed Imodium 2mg (15ml) via peg tube was administered on January 18, 2009 at 12:00 PM, 3:00 PM and 8:00PM. Further review revealed Imodium 2mg (15ml) via peg tube was administered on January 19, 2009 between the hours of 8:00 PM and 8:00AM and on January 20, 2009 at 3:30PM for loose stools. Review of the MAR dated January 2009 on March 6, 2009 at approximately 5:29 PM revealed Imodium 2mg via peg tube was not documented as administered on the above dates and times. There was no documented evidence Imodium 2 mg via gastric tube documented as administered on the MAR.</p> <p>10. Review of Resident #1's POS dated January</p>	I 401	<p><b>I 401: 8 &amp; 9</b> The RN has in-serviced the LPNs on accurate data collection (please see evidence herewith). The RN will in-service the LPNs quarterly on accurate and consistent data collection.</p> <p style="text-align: right;">03/28/09</p>	

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I 401	<p>Continued From page 17</p> <p>2009 on February 10, 2009 at approximately 12:00 PM revealed Resident #1 was ordered Lactulose Solution 30 ml twice a day via gastric tube and Senna Syrup (Senokot) 5 ml twice a day via gastric tube for bowel regulation. Review of the hospital discharge summary dated January 17, 2009 on February 10, 2009 at approximately 12:08 PM revealed Resident #1 was diagnosed with diarrhea and released to the group home with instructions to "hold Lactulose and Senokot until diarrhea stops." Review of Resident #1's telephone POS dated January 17, 2009 on February 10, 2009 at approximately 12:11 PM revealed an order for Imodium 2 mg(15ml) via peg tube after each loose stool. There was no documented evidence the Primary Care Physician (PCP) ordered Lactulose and Senokot to be held.</p> <p>11. Review of the hospital discharge summary dated January 17, 2009 on February 10, 2009 at approximately 12:09 PM revealed Resident #1 was diagnosed with diarrhea and released to the group home with instructions "if you continue to have severe diarrhea and not improving after 3 days contact your doctor or return to the emergency department". Review of Resident #1's nursing progress notes dated January 18-20, 2009 on March 8, 2009 at approximately 2:39 PM revealed Resident #1 continued to have diarrhea as evidenced by:</p> <p>January 18, 2009 between 8:00 PM to 8:00 AM : Resident #1 eliminated 400cc of loose stools;</p> <p>January 19, 2009 between the hours of 8:00 PM and 8:00AM : Resident #1 eliminated 1000cc of loose stools;</p> <p>January 19, 2009 at 3:00 PM : Resident #1</p>	I 401	<p>I 401: 10</p> <p>A written order was given to hold Lactulose and Senokot but the LPN on duty failed to transcribe the order on a POS. The RN has in-serviced the LPNs on the issue of transcribing orders, and will on a monthly basis track all orders so as to ensure that orders are transcribed and approved by the primary care physician.</p> <p style="text-align: right;">03/28/09</p>	
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I 401	<p>Continued From page 18</p> <p>eliminated 280 cc of loose stools;</p> <p>January 19, 2009 at 8:00 PM: Resident #1 eliminated 400cc of loose stools;</p> <p>January 20, 2009 at 7:30 AM: Resident #1 eliminated 200cc of watery loose stools;</p> <p>January 20, 2009 at 1:00 PM : Resident #1 eliminated 150cc of watery stool and</p> <p>January 20, 2009 at 3:30PM: Resident #1 eliminated 500cc of watery stool</p> <p>Review of Resident #1's Intake and Output Chart dated January 18, 2009 on March 6, 2009 at approximately 3:30 PM revealed Resident #1 continued to have diarrhea as evidenced by:</p> <p>January 18, 2009 at 12:00 PM : Resident #1 eliminated 120 cc of loose stools</p> <p>January 18, 2009 at 3:00 PM: Resident #1 eliminated 120 cc of loose stools;</p> <p>January 18, 2009 at 6:00PM: Resident #1 eliminated 150 cc of loose stools.</p> <p>Interview with the RN on February 10, 2009 at approximately approximately 11:25 AM revealed that the PCP was made aware on February 20, 2009 after 3:30 PM the resident was having loose stools and advised her to send the resident to the emergency department.</p> <p>There was no documented evidence the PCP was made aware the resident continued to have severe diarrhea until after 3:30 PM on January 20, 2009 and had to be transported to the emergency department.</p>	I 401	<p>I 401: 11</p> <p>In the future, the facility shall ensure that the primary care physician is made aware of such situation on a timely basis despite the fact that the discharge summary instruction "if you continue to have severe diarrhea and not improving after 3 days contact your doctor or return to the emergency department."</p> <p>The RN will, on a quarterly basis in-service the LPNs on the need of timely notification of the primary care physician.</p> <p style="text-align: right;">03/28/09</p>	

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I 401	<p>Continued From page 19</p> <p>12. Review of Resident #1's HMCP revised on January 2, 2009 on March 6, 2009 at approximately 6:47 PM indicated observe for symptoms of LTI frequent urge but small urine output and reddish or cloudy urine. Interview with the RN on February 10, 2009 at approximately 12:37 PM acknowledged Resident #1's urinary output was to be recorded on the Input and Output Chart. Review of Resident #1's Input and Output Chart dated January 16, 2009 on March 6, 2009 at approximately 6:52 PM revealed the amount of urine expelled by the resident was not documented on the Input and Output Chart after 6:00 AM. Further review revealed the amount of urine expelled by the resident was not documented on the Input and Output Chart on January 19-20, 2009. There was no documented evidence the amount of urine expelled by the resident was documented consistently on the Input and Output Chart.</p> <p>13. Review of Resident #1's POS dated August 21, 2008 on March 9, 2009 at approximately 6:32 PM revealed an order for Cipro 500 mg one peg tube twice a day. Further review revealed that twenty 500 mg tablets were dispensed. Review of the August 2008 MAR on March 9, 2009 at approximately 6:33 PM revealed Cipro 500 mg via peg tube began to be administered on August 22, 2008 at 7:00 AM. Further review revealed Cipro 500 mg via peg tube was not documented as administered on August 31, 2008 at 7:00 AM. There was no documented evidence Cipro 500 mg via peg tube was administered as ordered.</p>	I 401	<p>I 401: 12 Staff have been in-serviced on consistent data collection. The RN will on a monthly basis review data collection sheets to ensure consistent data collection.  <b>03/28/09</b></p> <p>I 401: 13 Staff have been in-serviced on proper documentation of medication administered. The RN will on a quarterly basis in-service the LPNs on adhering to physician's orders. And will on a monthly basis review the MARs to ensure compliance.  <b>03/28/09</b></p>	
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with</p>	I 422		

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**1422** Continued From page 20  
the resident ' s Individual Habilitation Plan.

This Statute is not met as evidenced by:  
Based on record review and staff interview he facility failed to follow doctor's orders in implementing the repositioning regimen for one of one resident in the investigation. (Resident #1)

The finding includes:

Record review on 2/11/2009 at 5:50pm revealed Resident #1's 2/2009 physician orders (POS) reflect he had a decubitus "ulcer to right ischium". Further record review revealed Resident #1's POS dated 12/5/2008 ordered to "turn and reposition [Resident #1] every 2 hours with no pressure on the right buttock." A review of the 12/2008 and 1/2009 data collection sheets revealed he was repositioned daily from a reclined position in his bed to being seated in his wheelchair between the hours of 8:00am to 10:00am from 12/1/2008 to 1/19/2009. The only documented exceptions are on 1/15/2009 and 1/17/2009 when he was hospitalized. Further review revealed he was positioned on his left side on 12/5, 12/17, 12/23, 12/25, 12/29, 12/30 and positioned on his right side on 12/9, 12/16, 12/21 between the hours of 10am and 12pm. He was also positioned on his left side on 12/10, 12/13, 12/28, 12/31, 1/5, 1/12, 1/14 and positioned on his right side on 12/5, 1/18 between the hours of 12pm and 2pm. The GHRMP failed to ensure that Resident #1 received consistent repositioning to alleviate the pressure off his right buttocks as ordered by the primary care physician.

**1422**

**1473**

**I 422**  
Staff have been in-serviced on proper documentation of repositioning. The House Manager (HM) will on a weekly basis (5 days a week) monitor repositioning of residents to ensure consistency.  
**03/28/09**

**1473** 3522.4 MEDICATIONS

The Residence Director shall report any irregularities in the resident ' s drug regimens to

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1473	<p>Continued From page 21</p> <p>the prescribing physician.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that any irregularities in the drug regimen was reported to the prescribing physician for one of one for one resident in the investigation. (Resident #1)</p> <p>The finding includes:</p> <p>1. Review of Resident #1's physician's orders (POS) dated December 21, 2008 on February 23, 2009 at approximately 1:09 PM revealed an order for Xenaderm ointment to be applied to sacral wound twice daily. Further review revealed Xenaderm ointment was discontinued on December 5, 2008. Review of Resident #1's, Skin Assessment Sheets dated December 1-31, 2008 on February 23, 2009 at approximately 1:15 PM revealed Xenaderm ointment continued to be applied to the sacral wound. There was no evidence that the PCP was made aware that the order for Xenaderm ointment was not discontinued on December 5, 2008.</p> <p>2. Review of Resident #1's physician's orders (POS) dated September 10, 2008 on February 10, 2009 at approximately 3:50PM revealed an order to administer Cipro 750 mg liquid via gastric tube twice a day for Urinary Tract Infection (UTI) until September 20, 2008. Review of the Medication Administration Record (MAR) dated September 2008 on February 10, 2009 at approximately 3:54 PM revealed that Resident #1 was not initially administered Cipro 750 mg via gastric tube until 7:00 PM, September 12, 2008. Interview with the Licensed Practical Nurse (LPN)</p>	1473	<p>I 473, 1</p> <p>In the future, the facility shall inform the PCP of a discontinuation of any treatment.</p> <p>The RN will on a quarterly basis remind the LPNs of the need to always inform the PCP of a discontinuation of treatment.</p> <p style="text-align: right;">03/28/09</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/11/2008
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1448 ROXANNA ROAD NW WASHINGTON, DC 20012
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1473	<p>Continued From page 22</p> <p>on February 10, 2009 at approximately 4:00 PM revealed the medication had not arrived from the pharmacist. There was no evidence that any irregularities in the drug regimen for the resident was reported to the prescribing physician.</p> <p>3. Review of Resident #1's POS dated September 10, 2008 on February 10, 2009 at approximately 4:15 PM revealed an order to administer Augmentin 875 mg liquid via gastric tube twice a day for UTI until September 20, 2008. Review of the MAR dated September 20, 2008 on February 10, 2009 at approximately 4:25 PM revealed that Resident #1 was not initially administered Augmentin 875 mg liquid via gastric tube until 7:00 PM on September 11, 2008. In an interview with the RN on February 10, 2009 at approximately 4:30 PM it was acknowledged Augmentin 875 mg liquid via gastric tube was not administered until 7:00 PM on September 11, 2008. There was no evidence that any irregularities in the drug regimen for the resident was reported to the prescribing physician.</p> <p>4. Review of Resident #1's POS dated August 21, 2008 on March 9, 2009 at approximately 6:42 PM revealed an order for Lopressor (Metoprolol Tartrate) 50 mg one-half tablet via peg tube every morning and one tablet via peg tube every evening. Review of the August 2008 MAR on March 9, 2009 at approximately 6:43 PM revealed Metoprolol Tartrate 50 mg via peg tube every evening was not transcribed. There was no evidence that any irregularities in the drug regimen for the resident was reported to the prescribing physician.</p> <p>5. Review of Resident #1's POS dated November, 2008 on March 9, 2009 at approximately 6:44 PM revealed an order for</p>	1473	<p>I 473, 2, 3 In the future, the facility shall rectify with the PCP irregularities in drug regimen.</p> <p>All medications that are not started on a timely manner will be reported to the PCP.</p> <p>The RN will ensure that all antibiotics are ordered stat so that they are expedited from the pharmacy and reach the facility within 24 hours. If the medications are not received from the pharmacy within 24 hours, the LPN or the RN will inform the PCP for a decision to be made immediately. 03/28/09</p> <p>I 473, 4 In the future, the facility shall inform the PCP of all irregularities in drug regimen. All medications ordered by the physician will be transcribed in a consistent and timely.</p> <p>The RN will in-serve the LPNs quarterly on transcribing all written and verbal orders. 03/28/09</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>WHOLISTIC HOME &amp; COMMUNITY BASED SE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1449 ROXANNA ROAD NW WASHINGTON, DC 20012</b>
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1473	<p>Continued From page 23</p> <p>Vitron-C 200mg /125 one tablet via peg tube twice daily. Review of the November 2008 MAR on March 9, 2009 at approximately 6:45 PM revealed Vitron-C 200mg /125 one tablet via peg tube twice daily was not documented as administered on November 1, 7, 16, 23, 26, 28 and 30, 2008. There was no evidence that any irregularities in the drug regimen for the resident was reported to the prescribing physician.</p> <p>6. Review of Resident #1's POS dated August 21, 2008 on March 9, 2009 at approximately 6:48 PM revealed an order for Vitamin C 500 mg twice a day. Review of the August 2008 MAR on March 9, 2009 at approximately 6:47 PM revealed Vitron-C 200mg /125 one tablet via peg tube twice daily with meals was documented as administered. There was no evidence that any irregularities in the drug regimen for the resident was reported to the prescribing physician.</p> <p>7. Review of Resident #1's POS dated August 21, 2008 on March 9, 2009 at approximately 6:50 PM revealed an order for Colace 100 mg twice a day for constipation. Review of the August 2008 MAR on March 9, 2009 at approximately 7:01 PM revealed Colace 100 mg twice a day for constipation was not transcribed on the MAR. There was no evidence that any irregularities in the drug regimen for the resident was reported to the prescribing physician.</p> <p>[Note: The MAR's for January thru July 2008 were not available]</p>	1473	<p>I 473, 5 Cross reference I 401:13 03/28/09</p> <p>I 473, 6 Cross reference I 473, 4. 03/28/09</p> <p>I 473, 7 Cross reference I 473, 4. 03/28/09</p>	
1478	<p>3522.6(d) MEDICATIONS</p> <p>The record for a resident 's prescribed controlled substances shall include the following:</p>	1478		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/11/2009
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1448 ROXANNA ROAD NW WASHINGTON, DC 20012
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I 478	<p>Continued From page 24</p> <p>(d) Date dispensed, amount and expiration date; and...</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to maintain records of the date dispensed and amount of all controlled drugs for one of one resident in the investigation. (Resident # 1 )</p> <p>The finding includes:</p> <p>The facility failed to provide evidence of the accurate disposition of the Controlled Schedule II Drug (Fentanyl Citrate) prescribed for Resident #1 as evidenced by:</p> <p>Review of the physician's orders dated January 23, 2008 on February 10, 2009 at approximately 10:10 AM revealed Resident # 1 was ordered Fentanyl Citrate 75 mcg/hr. transdermal patch to be applied topically every seventy-two hours for pain management. Review of the controlled medication utilization record on February 10, 2009 at approximately 10:15 AM revealed twenty Fentanyl Citrate 75 mcg/hr. transdermal patches were dispensed to the facility (date unknown). The initial dose of Fentanyl Citrate 75 mcg/hr. every seventy-two hours was began on September 1, 2008. Further review revealed the last documented dose of Fentanyl Citrate 75 mcg/hr. transdermal patch to be applied topically every seventy-two hours was on October 30, 2008 and there remained two Fentanyl Citrate 75 mcg/hr. transdermal patches. The two remaining Fentanyl Citrate 75 mcg/hr. transdermal patches were not recorded on the November 2008 controlled medication utilization record. Interview with the Registered Nurse (RN) on February 10, 2009 at approximately 10: 45 AM revealed she</p>	I 478	<p>I 478</p> <p>The RN will train the LPNs on a quarterly basis on the proper disposition of controlled drugs. Also the RN will train the LPNs on how to track Controlled Drugs relating to amount dispensed, amount administered and amount remaining.</p> <p>03/28/09</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD12-0076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/11/2009
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NAME OF PROVIDER OR SUPPLIER  WHOLISTIC HOME & COMMUNITY BASED SE	STREET ADDRESS, CITY, STATE, ZIP CODE 1449 ROXANNA ROAD NW WASHINGTON, DC 20012
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1478	Continued From page 25  had no knowledge of the disposition of the two remaining Fentanyl Citrate 75 mcg/hr. transdermal patches. There was no evidence that the facility's nursing staff correctly recorded the date dispensed and amount of the Controlled Schedule II Drug (Fentanyl Citrate).	1478		
1484	<p><b>3522.11 MEDICATIONS</b></p> <p>Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to remove medications that had worn labels from use for one of one resident in the investigation. (Resident #1)</p> <p>The finding includes:</p> <p>Observation on February 10, 2009, at approximately 9:50 AM revealed that Resident #1's container of 1% Silver Sulfadiazine (Silvadene) cream had a missing label. In an interview with the Licensed Practical Nurse (LPN) on February 10, 2009 at approximately 9:56 AM it was acknowledged the label was missing from the container of Silvadene cream was used for Resident #1. There was no evidence the facility replaced all medications that had missing labels from use.</p>	1484	<div style="border: 1px solid black; padding: 5px;"> <p><b>I 484</b> The facility RN will on a monthly basis designate an LPN to check all prescribed medications on a monthly basis so as to ensure that all medication labels are clearly visible. The nurse will also ensure that expired drugs are disposed off in accordance with Wholistic's policy.  03/28/09</p> </div>	