

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

PRINTED: 10/25/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2010
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 08	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 FRANKLIN STREET, NE WASHINGTON, DC 20017
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W 000 INITIAL COMMENTS

An recertification survey was conducted from September 13, 2010, through September 15, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five females with various levels of developmental disabilities.

The findings of the survey were based on observations at the group home, three day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.

W 000

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002**

NOV 5 2010

W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS

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.

This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients family members were informed of the risks and benefits of clients' treatment, for two of the three clients included in the sample. (Clients #2 and #3)

The findings include:

1. The facility failed to ensure that informed consent was obtained from Client #2's guardian prior to the administration of her psychotropic medications.

W 124

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Miatta Thomas</i>	TITLE <i>Vice President</i>	(X6) DATE 11/3/10
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	<p>Continued From page 1</p> <p>During the entrance conference on October 13, 2010, beginning at 8:55 a.m., the qualified mental retardation professional (QMRP) indicated that Client #2 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observations during the medication administration on October 13, 2010, at 7:10 p.m., revealed Client #2 was administered Clonazepam 0.5 mg, Gabapentin 300 mg and Amantadine 100 mg.</p> <p>Review of Client #2's current physician orders dated October 2010, on October 14, 2010, beginning at 3:10 p.m., revealed an order for Clonazepam 0.5 mg, twice a day (BID), Gabapentin 300 mg, BID, and Amantadine 100 mg, BID.</p> <p>The QMRP's statement was verified on October 14, 2010, at 3:30 p.m., through review of Client #2's psychological assessment dated December 2, 2009. According to the assessment, the client "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a guardian that was involved in her habilitation planning and decision making.</p> <p>At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the</p>	W 124			

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W 124	<p>Continued From page 2 psychotropic medication.</p> <p>2. The facility failed to provide evidence that informed consent was obtained from Client #3's guardian for psychotropic medications as evidenced below:</p> <p>Observations during the medication administration, on October 13, 2010, at 7:40 p.m., revealed that Client #3 received Seroquel 400 mg, Haldol 5 mg, Ativan 0.5 mg and Clozapine 200 mg. Interview with the trained medication employee (TME) after the medication administration indicated that the client received the aforementioned medication for schizophrenia and psychosis.</p> <p>Review of the client's current physician orders dated October 2010, on October 14, 2010, beginning at 12:01 p.m., confirmed the aforementioned medications. In addition, the client was ordered Cogentin 2 mg, once a day for tremors caused by other psychotropic drugs.</p> <p>Review of Client #3's Psychological Assessment dated January 22, 2010, on October 15, 2010, at approximately 2:00 p.m., revealed that the client was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of the client's record revealed that the guardian signed a consent for Clozapine 200 mg, three times a day, dated May 10, 2010. However there was no consent for the Seroquel, Haldol, or the Ativan.</p> <p>Interview with the QMRP on October 15, 2010, at approximately 2:30 p.m., revealed that there was signed consent for all of Client #3's psychotropic medications. However, the facility failed to</p>	W 124	<p>Provider is transitioning to Electronic Medical Records. New PrecisionCare Software shall allow for ticklers/reminders for consent for psychotropic drugs. Until transition is complete QMRE shall, through ^{thru} monthly notes, address all psychotropic medications and acknowledge receipt of consent(s).</p>	11/15/10

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W 124	Continued From page 3 provide evidence that the potential risks involved in using these medications, or her right to refuse treatment had been explained to the client and/or her guardian, prior to the implementation of the psychotropic medication.	W 124		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for one of three clients in the sample. (Client #1) The finding includes: [Cross Reference W249]. The facility's QMRP failed to implement each clients individual program plan IPP as accepted by the interdisciplinary team (IDT) for Client #1.	W 159		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided opportunities to make a choice during snack time, for five of the five clients	W 247	See W249	

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W 247	Continued From page 4 residing in the facility. (Clients #1, #2, #3, #4, and #5) The finding includes: On October 13, 2010, at 4:21 p.m., direct care staff was observed preparing the client's snack. Interview with the direct care staff, seconds later, indicated that she was preparing Client #1, #2, #3, #4, #5, and #6's snack. At 4:25 p.m., the direct care staff was observed giving Clients #1, #2, #3, #4, and #5 a bowl of grapes. Review of the snack list on October 13, 2010, at approximately 4:30 p.m., revealed a variety of snack items. During the environmental inspection on October 14, 2010, at approximately 11:20 a.m., were observed a variety of snacks, from the snack list, in the refrigerator and/or the pantry. Additionally, review of each client's Individual Support Plans during the survey revealed that staff should provide each client with a variety of choices. At no time during snack time were the clients given the opportunity to select a snack from the variety of snack choices.	W 247		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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.	W 249	Staff have been re-trained Privacy, respect and choices. Held 10/29/10.	10/29/10

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W 249	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and reocrd review, the facility failed to implement each clients individual program plan (IPP) as accepted by the interdisciplinary team (IDT), for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>During the entrance conference on October 13, 2010, beginning at 8:55 a.m., the QMRP revealed that the provider took over Client #1's home in May 2010. The client was transferred to another home within the agency on July 9, 2010. Further interview revealed that the client's thirty day review was held on June 2010.</p> <p>According to the occupational therapy assessment dated December 12, 2009, on October 15, 2010, at approximately 10:45 a.m., the following objectives were recommended:</p> <ul style="list-style-type: none"> - [The client] will make her bed with verbal reminders on 80% of trials for three consecutive months; and - [The client] will load the dishwasher with verbal reminders on 80% of trials for three consecutive months. <p>Review of Client #1's IPP dated June 6, 2010, on October 15, 2010, at approximately 10:30 a.m., revealed no evidence of the aforementioned objectives.</p> <p>Further interview with the QMRP on October 15, 2010, at 11:33 a.m., acknowledged that she omitted the objectives. However she would</p>	W 249	<p>Objectives have been implemented accordingly. please find documentation attached.</p>	11/1/10
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W 249 W 262	<p>Continued From page 6 implement the objectives immediately.</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for one of three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Interview with the qualified mental retardation professional (QMRP) during the entrance conference on October 13, 2010, beginning at 8:55 a.m., indicated that the provider took over Client #1's home in May 2010, and then the client was transferred to another home within the agency on July 9, 2010.</p> <p>Observations during the medication administration, on October 13, 2010, at 7:58 p.m., revealed that Client #1 received Zyprexa 10 mg. Interview with the trained medication employee (TME) after the medication administration, indicated that the client received the medication for her maladaptive behaviors.</p> <p>Interview with the QMRP and the review of Client #1's record on October 14, 2010, at approximately 10:00 a.m., revealed the client had</p>	W 249 W 262		

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W 262	Continued From page 7 a behavior support plan (BSP) to address her targeted behaviors. Further review of the BSP dated January 25, 2010, confirmed that it addressed her maladaptive behaviors of physical aggression, SIB, verbal aggression and tantruming. Review of the HRC minutes, from May 2010 through October 2010, on October 15, 2010, beginning at 11:40 a.m., revealed that the HRC did not review the client's psychotropic medications.	W 262	Newly admitted client was inadvertently also omitted from HRC process. She has been incorporated and HRC has approved her medication regimen. EMR system will remind QMRP of HRC approval one new individual admitted to Wholistic.	11/2/10
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly, for one of three clients in the sample. (Client #1) The finding includes: Interview with the qualified mental retardation professional (QMRP) during the entrance conference on October 13, 2010, beginning at 8:55 a.m., indicated that the provider took over Client #1's home in May 2010, and the client was transferred to another home within the agency on July 9, 2010. On October 13, 2010, at 7:58 p.m., Client #1 was observed receiving Zyprexa, Enulose, Hydroxyzine, Zocor, Enablex and Calcium with Oyster D. Interview with the registered nurse (RN) on	W 362		

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W 362	Continued From page 8 October 14, 2010, at 2:30 p.m., revealed the pharmacist should come to the facility every three months to conduct reviews of the clients' medications. The review of Client #1's medical records on October 14, 2010, at 10:30 a.m., revealed no pharmacy reviews were documented between May, 2010 and October 13, 2010. Continued discussion with the QMRP and RN on October 15, 2010, at 1:00 p.m., acknowledged that the pharmacist had not reviewed the client's medication regimen quarterly as required.	W 362		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure clients medications were administered without error, for one of five clients in the facility. (Client #4) The finding includes: On October 13, 2010, at 6:15 p.m., Client #4 was observed eating dinner. Observations during the medication administration on October 13, 2010, at 7:24 p.m., revealed that Client #4 was administered Renvela F/C 800 mg tablet. Interview with the trained medication employee (TME) indicated that the medication was used for hyperphosphatemia. Review and reconciliation of the medication observation with the client's current physician orders (POS) dated October	W 369	<i>Staff has been retrained accordingly. Please find training documentation attached.</i>	<i>10/19/10</i>

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W 369	<p>Continued From page 9</p> <p>2010, on October 13, 2010, at 8:25 p.m., revealed that the Renvela F/C 800 mg tablet was prescribed before meals, three times per day.</p> <p>Interview with the TME indicated that she "always" begins her medication pass at 7:00 p.m., because Client #4 receives a medication at bedtime (8:00 p.m.). Interview with the registered nurse (RN) on October 13, 2010, at 8:50 p.m., revealed that the client received the medication "only" 30 minutes after she completed her meal and it had no significant bearing because it was not used to treat a GI problem. Further interview revealed that Renvela F/C medication is used in patients to control serum phosphorus levels.</p> <p>Review of Client #4's laboratory studies dated September 1, 2010, on October 14, 2010, at approximately 10:00 a.m., revealed a phosphorus level of 5.2. The phosphorus level range is 2.5 - 4.5, which indicated that the client had elevated phosphorus levels.</p>	W 369			

Health Regulation Administration

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I 000	<p>INITIAL COMMENTS</p> <p>An licesnure survey was conducted from September 13, 2010, through September 15, 2010. A random sample of three residents was selected from a population of five females with various levels of developmental disabilities.</p> <p>The findings of the survey were based on observations at the group home, two day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.</p>	I 000		
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan (IHP), for one of the three residents included in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>During the entrance conference on October 13, 2010, beginning at 8:55 a.m., the QMRP revealed that the provider took over Resident #1's home in May 2010. The resident was transferred to another home within the agency on July 9, 2010. Further interview revealed that the resident's thirty day review was held on June 2010.</p> <p>According to the occupational therapy</p>	I 422	<p>See W249</p>	

Health Regulation Administration

Miatta Thomas

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Vice President

(X6) DATE

10/15/10

Health Regulation Administration

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I 422	Continued From page 1 assessment dated December 12, 2009, on October 15, 2010, at approximately 10:45 a.m., the following objectives were recommended: - [The resident] will make her bed with verbal reminders on 80% of trials for three consecutive months; and - [The resident] will load the dishwasher with verbal reminders on 80% of trials for three consecutive months. Review of Resident #1's IPP dated June 6, 2010, on October 15, 2010, at approximately 10:30 a.m., revealed no evidence of the aforementioned objectives. Further interview with the QMRP on October 15, 2010, at 11:33 a.m., acknowledged that she omitted the objectives. However she would implement the objectives immediately.	I 422		
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 observation, staff interview and record review, the Group for Mentally Retarded Persons (GHMRP) failed to report any irregularities to the Primary Care Physician (PCP), for one of the five residents residing in the GHMRP. (Resident #4) The finding includes: On October 13, 2010, at 6:15 p.m., Resident #4 was observed eating dinner. Observations during the medication administration on October 13,	I 473		

Health Regulation Administration

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(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 473	<p>Continued From page 2</p> <p>2010, at 7:24 p.m., revealed that Resident #4 was administered Renvela F/C 800 mg tablet. Interview with the trained medication employee (TME) indicated that the medication was used for hyperphosphatemia. Review and reconciliation of the medication observation with the resident's current physician orders (POS) dated October 2010, on October 13, 2010, at 8:25 p.m., revealed that the Renvela F/C 800 mg tablet was prescribed before meals, three times per day.</p> <p>Interview with the TME indicated that she "always" begins her medication pass at 7:00 p.m., because Resident #4 receives a medication at bedtime (8:00 p.m.). Interview with the registered nurse (RN) on October 13, 2010, at 8:50 p.m., revealed that the client received the medication "only" 30 minutes after she completed her meal and it had no significant bearing because it was not used to treat a GI problem. Further interview revealed that Renvela F/C medication is used in patients to control serum phosphorus levels.</p> <p>Review of Client #4's laboratory studies dated September 1, 2010, on October 14, 2010, at approximately 10:00 a.m., revealed a phosphorus level of 5.2. The phosphorus level range is 2.5 - 4.5, which indicated that the client had elevated phosphorus levels.</p> <p>Interview and review with the TME/House Manager on October 15, 2010, at approximately 10:30 a.m., revealed an incident report form. The incident report form indicated that Client #4 was given Renvela 800 mg after dinner instead of before dinner, as prescribed. Further review revealed that the administrator, guardian and registered nurse were informed. However there was no evidence that the prescribing physician was notified.</p>	I 473	<p><i>See W 369</i></p> <p><i>PCP for client was on the afternoon of 10/15/10. Please be advised that 24 hour time period had not lapsed. Staff have been re-trained to <u>immediately</u> notify staff.</i></p>	<i>10/15/10</i>

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I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retardation Persons (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws, for three of three residents included in the sample (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>1. The GHMRP failed to ensure that informed consent was obtained from Resident #2's guardian prior to the administration of her psychotropic medications.</p> <p>During the entrance conference on October 13, 2010, beginning at 8:55 a.m., the qualified mental retardation professional (QMRP) indicated that Resident #2 received psychotropic medications to address her maladaptive behaviors. Further interview revealed that the resident did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observations during the medication administration on October 13, 2010, at 7:10 p.m., revealed Resident #2 was administered Clonazepam 0.5 mg, Gabapentin 300 mg and Amantadine 100 mg.</p>	I 500	See W262	

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I 500	<p>Continued From page 4</p> <p>Review of Resident #2's current physician orders (POS) dated October 2010, on October 14, 2010, beginning at 3:10 p.m., revealed an order for Clonazepam 0.5 mg, twice a day (BID), Gabapentin 300 mg, BID, and Amantadine 100 mg, BID.</p> <p>The QMRP's statement was verified on October 14, 2010, at 3:30 p.m., through review of Resident #2's psychological assessment dated December 2, 2009. According to the assessment, the Resident "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the resident had a guardian that was involved in her habilitation planning and decision making.</p> <p>At the time of the survey, the GHMRP failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to the administration of the psychotropic medication.</p> <p>2. The GHMRP failed to provide evidence that informed consent was obtained from Resident #3's guardian for psychotropic medications as evidenced below:</p> <p>Observations during the medication administration, on October 13, 2010, at 7:40 p.m., revealed that Resident #3 received Seroquel 400 mg, Haldol 5 mg, Ativan 0.5 mg and Clozapine 200 mg. Interview with the trained medication employee (TME) after the medication administration indicated that the resident received the aforementioned medication for schizophrenia and psychosis.</p>	I 500		

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I 500	<p>Continued From page 5</p> <p>Review of the Resident #3's current POS dated October 2010, on October 14, 2010, beginning at 12:01 p.m., confirmed the aforementioned medications. In addition, the resident was ordered Cogentin 2 mg, once a day for tremors caused by other psychotropic drugs.</p> <p>Review of Resident #3's Psychological Assessment dated January 22, 2010, on October 15, 2010, at approximately 2:00 p.m., revealed that the resident was not competent to make decisions regarding her health, safety, financial or residential placement. Further review of the resident's record revealed that the guardian signed a consent for Clozapine 200 mg, three times a day, dated May 10, 2010. However there was no consent for the Seroquel, Haldol, or the Ativan.</p> <p>Interview with the QMRP on October 15, 2010, at approximately 2:30 p.m., revealed that there was signed consent for all of Resident #3's psychotropic medications. However, the GHMRP failed to provide evidence that the potential risks involved in using these medications, or her right to refuse treatment had been explained to the resident and/or her guardian, prior to the implementation of the psychotropic medication.</p> <p>3. 7-1305.05 (h)"No medication shall be administered unless at the written or verbal order of a licensed physician, noted promptly in the patients medical record and signed by the physician within 24 hours."</p> <p>Review of Resident #1's medical record on September 13, 2010, beginning at 2:30 p.m., revealed the following telephone orders:</p> <p>- Administer Metamucil OT orange, 2 teaspoons</p>	I 500	See W124	

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I 500	Continued From page 6 in 8 ounces of water, every evening to prevent constipation, dated October 6, 2010; - Discontinue Crestor 5 mg, by mouth, once a day. Start Simvastatin 20 mg, by mouth at bedtime, dated July 28, 2010; - Add the following diagnoses: Hyperlipidemia NOS, Mitral valve regurgitation, etc, Start Crestor 5 mg, by mouth, once a day, dated July 8, 2010; and - Admission order dated May 17, 2010. Further review of the POS revealed that the order did not have a signature by the prescribing physician. On October 14, 2010, at approximately 2:00 p.m., in a face to face interview with the registered nurse revealed that the telephone orders should be signed within 48 hours. At that time, she confirmed that the POS had not been signed.	I 500	<i>RN has been re-trained on time frame to ensure telephone order(s) signed by PCP. RN is new to the ICF/IDD system but has made tremendous strides. We are confident that this will not re-occur. PCP has sign POS.</i>	<i>11/1/10</i>