

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

PRINTED: 09/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/25/2011
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09			STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, 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) COMPLETION DATE	
W 000	INITIAL COMMENTS A recertification survey was conducted from August 24, 2011 through August 25, 2011. A sample of three clients was selected from a population of five females with various intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with one family member/guardian, one client, and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.	W 000			
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 observation, interview, and record review, the qualified intellectual disabilities professional (QIDP) failed to coordinate, monitor, integrate each client's active treatment, for one of three clients included in the sample. (Client #3) The findings include: 1. Cross refer to W189. The facility's QIDP failed to ensure that each staff was effectively trained on Client #3's diet change as recommended by nutritionist. 2. Cross refer to W249. The facility's QIDP failed to ensure Client #3's Behavior Support Plan	W 159			

Received 9/16/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St, N.E.
Washington, D.C. 20002

see W189

see W249

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mattie Jones* TITLE: *Vice President* (X6) DATE: *9/16/11*

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 159 W 189	Continued From page 1 (BSP) was implemented consistently. 483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each staff was effectively trained on Client #3's diet change as recommended by nutritionist, for one of three clients included in the sample. (Client #3) The findings include: Evening observation conducted on August 24, 2011, at 4:20 p.m., revealed Client #3 received a bowl full of graham crackers served in a standard size bowl. At 4:32 p.m., Client #3 was given a bowl full of her store bought birthday cake in the same bowl. At 4:42 p.m., the client received a smaller portion of graham crackers in the same bowl. At 5:15 p.m., staff was observed to give Client #2 another serving of birthday cake in the same bowl. At approximately 5:40 p.m., Client #3 was served her dinner which indicated a (double portion) of a 3 ounce hamburger (beef), fat free cheese, regular hamburger bun, mustard, pickles, tomatoes, onions, oven French fries, and a caramel Jell-O pudding. The client consumed a few French fries (3), both hamburger buns, approximately one half of one hamburger, and all of her caramel Jell-O pudding. Interview with the qualified intellectual disabilities	W 159 W 189	

Staff have been re-trained on low fat, low cholesterol diets. Please see attached training sheets/documentation. In addition, QIDP will observe dining and document in quarterly or Monthly note staff's competencies regarding meal preparation.

9/10/11

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W 189 Continued From page 2

professional (QIDP) on August 24, 2011, at 6:11 p.m., revealed Client #3 was prescribed a low fat, low cholesterol diet with double portions. At approximately 6:15 p.m., the registered nurse (RN) added that Client #3's diet was changed recently to low fat, low cholesterol due to an elevation in her cholesterol. The RN stated that Client #3 should have not received two bowls of cake on August 17, 2011.

Review of Client #3's medical records on August 25, 2011, at approximately 9:50 a.m., revealed a written physician order (POs) dated August 5, 2011. The POs revealed to discontinue Client #3's current diet order and start providing low fat, low cholesterol diet with double portions. Review of Client #3's laboratory studies dated July 14, 2011, at 10:01 a.m., revealed the following levels and ranges:

- Overall cholesterol level was 215. The range was 120 to 200.
- HDL level was 99. The range was 40 to 59 and;
- LDL level was 110. The range was 0 to 99.

The March 26, 2011, lab revealed that the HDL was 67 which were out of range. The range was 40 to 59.

Continued interview with the QIDP on August 25, 2011, at approximately 10:15 a.m., revealed that all staff had received training on the Client #3's recent diet change, but she was not able to produce any evidence of the training. Review of the in service training records on the same day at approximately 1:45 p.m., revealed that all staff had received general training on low fat, low cholesterol diets on May 20, 2011, by the

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W 189 Continued From page 3
nutritionist.

W 189

At the time of the survey, there was no documented evidenced that training had been effective.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

W 249

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.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to ensure a client's Behavior Support Plan (BSP) was implemented consistently, for one of three clients included in the sample. (Client #3)

The finding includes:

On August 24, 2011, beginning at 12:50 p.m., observations conducted at the day program revealed Client #3 was observed to have staff that remained in close proximity. Interview with the staff revealed that she was assigned 1:1 duties and responsibilities for the client. At 1:11 p.m., Client #3 got up from her seat, walked over to the surveyor and started rubbing my right knee. A few seconds later, the staff verbally prompted the client not to touch. At 1:17 p.m., Client #3 got up from her seat again, walked over to the

Staff have been retrained on the 1:1 duties and responsibilities. Please see attached documentation. QIDP shall visit Day Program on a quarterly basis and document in note if the proper interventions occur regarding implementation of the BSP for Client #3. 9/10/11

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W 249	<p>Continued From page 4</p> <p>surveyor and hugged the surveyor tightly without physical intervention from staff. The surveyor had to pull away from the client. The staff then verbally prompted Client #3 to stop.</p> <p>Interview with the day program's staff on August 24, 2011, at approximately 1:20 p.m., revealed that Client #3 received 1:1 staffing 8 hours a day while at the day program for safety and to manage her maladaptive behaviors (i.e. inappropriate touching of others (kissing, sniffing, hugging, etc.), verbal aggression, masturbation, and property destruction. Further interview with Client #3's 1:1 staff revealed that she should have intervened when the client got up from her seat to hug the surveyor. When asked, the staff stated that she had received training on Client #3's BSP in July 2011 by the home/day programs psychologist.</p> <p>On August 25, 2011, at 1:47 p.m., review of Client #3's BSP dated July 29, 2011, confirmed the staff's interview of the aforementioned maladaptive behaviors. Further review of Client #3's BSP revealed the 1:1 staff should model hand shaking for Client #3 and then verbally directed her to do the same. Continued review of Client #3's BSP revealed a staff training sheet that confirmed that the 1:1 staff had received training in July 2011.</p> <p>At the time of the survey, there was no evidence that the day program staff implemented Client #3 BSP as recommended.</p>	W 249	
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES	W 325	
	The facility must provide or obtain annual physical examinations of each client that at a minimum		

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W 325	<p>Continued From page 5 includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure routine laboratory testing as determined necessary by the physician, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On August 24, 2011, beginning at 7:06 p.m., Client #2 was observed being administered Buspar, Depakote, Cogentin, and Risperdal. During the medication administration, interview with the medication nurse indicated that the medications were used for the treatment of intermittent explosive disorder.</p> <p>On August 25, 2011, at 9:30 a.m., review of Client #2's physician's orders (POS) dated July 2010 revealed a lab order for the client to receive a urinalysis with culture and sensitivity (C & S) every year. Subsequent review of her medical records revealed that the C & S levels were obtained on August 16, 2010.</p> <p>Interview with the registered nurse (RN) on August 25, 2011, at 12:10 p.m., confirmed that the studies were not completed as ordered nor had an appointment been scheduled.</p> <p>The facility's nursing services failed to maintain an effective system to ensure that clients' laboratory studies were performed at the</p>	W 325	<p>Labs have subsequently been completed for client # 9/10/11</p> <p>2. RN shall utilize the newly implemented EMR system and import and track Labs and other medical issues by October 1st 2011. The comprehensive use of the EMR shall rectify the issue of lab work slipping through the cracks.</p>	

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W 325 W 441	<p>Continued From page 6 frequencies ordered by the PCP.</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for four of four clients residing in the facility. (Clients #1, #2, #3, #4, and #5)</p> <p>The finding includes:</p> <p>Interview with the House Manager (HM) on August 24, 2011, at 2:43 p.m., revealed that the facility had at least five methods of egress (front door, back door, back door on 3rd floor, side door, and the basement door). Review of the facility's fire drill records on August 24, 2011, beginning at 2:45 p.m., revealed that most of the fire drills were conducted utilizing the front door, back door, and side door exits. Further review of the fire drill records revealed that the basement door exit was not used from August 2010 to present. At 2:51 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed the laundry facilities are located in the basement and the client's actively participate in cleaning their clothes. At 3:16 p.m., the QIDP and HM confirmed that the basement door exit was not utilized during the past year. There was no evidence on file at the time of survey to substantiate that all exits were used.</p>	W 325 W 441	<p>Provider asserts that use of 4 of 5 methods of egress meet the requirement of "evacuations drills under <u>varied conditions</u>". The standard does not say 'all egress'. Notwithstanding, staff have been re-trained on the fire drill protocol. Please find documentation attached.</p> <p>9/10/11</p>

Health Regulation & Licensing Administration

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 24, 2011 through August 25, 2011. A sample of three residents was selected from a population of five females with various intellectual and developmental disabilities.</p> <p>The findings of the survey were based on observations and interviews with one family member/guardian, one resident, and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.</p>	I 000		
I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative support had been provided to effectively meet the needs, for one of three residents included in the sample. (Resident #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross refer to W189. The GHPID's QIDP failed to ensure that each staff was effectively trained on Resident #3's diet change as recommended by nutritionist. 2. Cross refer to W249. The GHPID's QIDP failed to ensure Resident #3's Behavior Support Plan (BSP) was implemented consistently. 	I 180	<p>see W189</p> <p>see W249</p>	

Health Regulation & Licensing Administration

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

Michele Shavers

TITLE

Vice President

(X6) DATE *

9/16/11

Health Regulation & Licensing Administration

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I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to ensure that each staff was effectively trained on Resident #3's diet change as recommended by nutritionist, for one of three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>Evening observation conducted on August 24, 2011, at 4:20 p.m., revealed Resident #3 received a bowl full of graham crackers served in a standard size bowl. At 4:32 p.m., Resident #3 was given a bowl full of her store bought birthday cake in the same bowl. At 4:42 p.m., the resident received a smaller portion of graham crackers in the same bowl. At 5:15 p.m., staff was observed to give Resident #2 another serving of birthday cake in the same bowl. At approximately 5:40 p.m., Resident #3 was served her dinner which indicated a (double portion) of a 3 ounce hamburger (beef), fat free cheese, regular hamburger bun, mustard, pickles, tomatoes, onions, oven French fries, and a caramel Jell-O pudding. The resident consumed a few French fries (3), both hamburger buns, approximately one half of one hamburger, and all of her caramel Jell-O pudding.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on August 24, 2011, at 6:11 p.m., revealed Resident #3 was prescribed a low fat, low cholesterol diet with double portions. At approximately 6:15 p.m., the registered nurse (RN) added that Resident #3's diet was changed</p>	I 222	

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I 222	<p>Continued From page 2</p> <p>recently to low fat, low cholesterol due to an elevation in her cholesterol. The RN stated that Resident #3 should have not received two bowls of cake on August 17, 2011.</p> <p>Review of Resident #3's medical records on August 25, 2011, at approximately 9:50 a.m., revealed a written physician order (POs) dated August 5, 2011. The POs revealed to discontinue Resident #3's current diet order and start providing low fat, low cholesterol diet with double portions. Review of Resident #3's laboratory studies dated July 14, 2011, at 10:01 a.m., revealed the following levels and ranges:</p> <ul style="list-style-type: none"> -Overall cholesterol level was 215. The range was 120 to 200; -HDL level was 99. The range was 40 to 59 and; -LDL level was 110. The range was 0 to 99. <p>The March 26, 2011, lab revealed that the HDL was 67 which were out of range. The range was 40 to 59.</p> <p>Continued interview with the QIDP on August 25, 2011, at approximately 10:15 a.m., revealed that all staff had received training on the Resident #3's recent diet change, but she was not able to produce any evidence of the training. Review of the in service training records on the same day at approximately 1:45 p.m., revealed that all staff had received general training on low fat, low cholesterol diets on May 20, 2011, by the nutritionist.</p> <p>At the time of the survey, there was no documented evidenced that training had been effective.</p>	I 222	

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1 400	Continued From page 3	1 400		
1 400	3520.2(j) 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: (j) Recreation This Statute is not met as evidenced by: Based on interview and record review, the GHPID failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHPID, as required by District of Columbia law, in the following disciplines or area: (j) Recreation The finding include: Review of the personnel records on August 25, 2011, beginning at 9:00 a.m., revealed that a current license/professional certification was not available for the Recreation Therapist. At approximately 11:00 a.m., the GHPID's qualified intellectual disabilities professional confirmed that the license/professional credentialing for the Recreation Therapist was not available for review. Title 3, Chapter 12 of the District of Columbia	1 400		

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1400	Continued From page 3	1400	
1400	3520.2(j) PROFESSION SERVICES: GENERAL PROVISIONS	1400	
	<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>(j) Recreation</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHPID failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHPID, as required by District of Columbia law, in the following disciplines or area:</p> <p>(j) Recreation</p> <p>The finding include:</p> <p>Review of the personnel records on August 25, 2011, beginning at 9:00 a.m., revealed that a current license/professional certification was not available for the Recreation Therapist. At approximately 11:00 a.m., the GHPID's qualified intellectual disabilities professional confirmed that the license/professional credentialing for the Recreation Therapist was not available for review.</p> <p>Title 3, Chapter 12 of the District of Columbia</p>		

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09		STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, 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 400	Continued From page 4 Official Code SUBCHAPTER V. LICENSING, REGISTRATION, OR CERTIFICATION OF HEALTH PROFESSIONALS § 3-1205.01. License, registration, or certification required. (a) A license issued pursuant to this chapter is required to practice medicine, acupuncture, chiropractic, registered nursing, practical nursing, dentistry, dental hygiene, dietetics, marriage and family therapy, massage therapy, naturopathic medicine, nutrition, nursing home administration, occupational therapy, optometry, pharmaceutical detailing, pharmacy, physical therapy, podiatry, psychology, social work, professional counseling, audiology, speech-language pathology, respiratory care, advanced practice addiction counseling, or to practice as an anesthesiologist assistant, physician assistant, physical therapy assistant, polysomnographic technologist, occupational therapy assistant, or surgical assistant in the District, except as otherwise provided in this chapter.	I 400	<i>§ 3-1205.01 does not have a license, registration or certification requirement for recreation therapy. Please advise accordingly.</i> <i>9/10/11</i>
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 observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure professional services that included both diagnosis and evaluation, including identification of	I 401	

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I 401	<p>Continued From page 5</p> <p>developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident, for one of three residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On August 24, 2011, beginning at 7:06 p.m., Resident #2 was observed being administered Buspar, Depakote, Cogentin, and Risperdal. During the medication administration, interview with the medication nurse indicated that the medications were used for the treatment of intermittent explosive disorder.</p> <p>On August 25, 2011, at 9:30 a.m., review of Resident #2's physician's orders (POS) dated July 2010 revealed a lab order for the resident to receive a urinalysis with culture and sensitivity (C & S) every year. Subsequent review of her medical records revealed that the C & S levels were obtained on August 16, 2010.</p> <p>Interview with the registered nurse (RN) on August 25, 2011, at 12:10 p.m., confirmed that the studies were not completed as ordered nor had an appointment been scheduled.</p> <p>The GHPID's nursing services failed to maintain an effective system to ensure that residents' laboratory studies were performed at the frequencies ordered by the PCP.</p>	I 401	<p><i>SEE W325 EMR system, PrecisionCare Software, shall be implemented to track and remind RN of Labs and other request by the PCP.</i></p> <p><i>9/10/11</i></p>
I 422	3521.3 HABILITATION AND TRAINING	I 422	
	<p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p>		

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	<p>I 422 Continued From page 6</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that residents' training objectives were implemented in accordance with their Individual Support Plan (ISP), for one of three residents included in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On August 24, 2011, beginning at 12:50 p.m., observations conducted at the day program revealed Resident #3 was observed to have staff that remained in close proximity. Interview with the staff revealed thate she was assigned 1:1 duties and responsibilities for the resident. At 1:11 p.m., Resident #3 got up from her seat, walked over to the surveyor and started rubbing my right knee. A few seconds later, the staff verbally prompted the resident not to touch. At 1:17 p.m., Resident #3 got up from her seat again, walked over to the surveyor and hugged the surveyor tightly without physical intervention from staff. The surveyor had to pull away from the resident. The staff then verbally prompted Resident #3 to stop.</p> <p>Interview with the day program's staff on August 24, 2011, at approximately 1:20 p.m., revealed that Resident #3 received 1:1 staffing 8 hours a day while at the day program for safety and to manage her maladaptive behaviors (i.e. inappropriate touching of others (kissing, sniffing, hugging, etc.), verbal aggression, masturbation, and property destruction. Further interview with Resident #3's 1:1 staff revealed that she should have intervened when the resident got up from her seat to hug the surveyor. When asked, the staff stated that she had received training on</p>	I 422	

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I 422	Continued From page 7 Resident #3's BSP in July 2011 by the home/day programs psychologist. On August 25, 2011, at 1:47 p.m., review of Resident #3's BSP dated July 29, 2011, confirmed the staff's interview of the aforementioned maladaptive behaviors. Further review of Resident #3's BSP revealed the 1:1 staff should model hand shaking for Resident #3 and then verbally directed her to do the same. Continued review of Resident #3's BSP revealed a staff training sheet that confirmed that the 1:1 staff had received training in July 2011. At the time of the survey, there was no evidence that the day program staff implemented Resident #3 BSP as recommended.	I 422	See W 249 Staff have been retrained. 9/10/11 Please see documentation.
I 484	3522.11 MEDICATIONS 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. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) nurse failed to remove medications with worn labels from use, for two of the five residents residing in the facility. (Residents #1 and #4) The findings include: 1. On August 25, 2011, beginning at 10:45 a.m., during the environmental inspection, a bottle of Metoconazole 2% shampoo was observed in Resident #1's personal hygiene kit. Further observation revealed that the bottle had an	I 484	Home manager shall conduct monthly audit of individuals personal hygiene kits to ensure all worn, illegible, expired or missing labels are promptly destroyed. 9/10/11

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1 484	<p>Continued From page 8</p> <p>expired date of April 2011.</p> <p>2. On August 25, 2011, beginning at 10:45 a.m., during the environmental inspection, a bottle of Thera-Derm lotion was observed in Resident #4's personal hygiene kit. Further observation revealed that the expiration date was worn on the pharmacy label. According to the label, the only observed information was the Resident #4's name.</p> <p>During the environmental inspection, the House Manager and licensed practical nurse confirmed that aforementioned findings.</p>	1 484	