

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

PRINTED: 04/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/12/2012
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032
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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) COMPLETION DATE
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W 000 INITIAL COMMENTS

W 000

A recertification survey was conducted from April 10, 2012 through April 12, 2012. A sampling of three clients was selected from a population of six individuals with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process.

The findings of the survey were based on observations in the home and one day program, interviews with direct support staff, day program and administrative staff, as well as a review of client and administrative records, including incident reports.

Received 6/20/12
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

W 159

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]
483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

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, staff interview and record verification, the qualified intellectual disabilities professional (QIDP) failed to coordinate, integrate, and monitor services, for one of three clients in the sample. (Client #2)

The findings include:

1. The QIDP failed to ensure a system was developed to monitor Client #2's progress

W159

This Standard will be met as evidenced by:

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1. QDDP will coordinate with PT to revise Client #2 PT goal. The PT goal will address the need for the staff to measure how far Client#2 walked. Staff will be retrained on any revisions to the goal.

2. A new evaluation should be scheduled to determine the appropriateness of the amplifier given that Client #2 at times refuses to use it. After the evaluation, the QDDP will ensure that the communication goal is implemented as written.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>T. J. ...</i>	TITLE Director of Residential Services	(X6) DATE 5/11/12
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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 159	<p>Continued From page 1</p> <p>toward his ambulation goal, as evidenced below:</p> <p>On April 10, 2012, at 12:28 p.m., Client #2 was observed seated in a regular chair at a table in a treatment room with his peers. Interview with the day program instructor on the same day at approximately 12:35 p.m., revealed that Client #2 was encouraged to sit in regular chairs, and sometimes the recliner at his day program. The day program instructor also indicated that the client was encouraged to walk short distances, to use his wheelchair for distance travel, and to use his wheelchair for safety, if he refused to walk. The instructor stated the client walked more in the past. However, after returning to day treatment from an extended medical absence (fall of 2011), the client did not want to walk much.</p> <p>On April 10, 2012, at 4:17 p.m., direct support staff #1 asked Client #2, "Let's go for a walk?" The client responded by saying, "Nope, nope, nope" repeatedly, then refused to stand up with assistance of staff using his gait belt. Staff indicated that it was sometimes very difficult to get the client to walk and that his ambulation skills had declined after his illness during the fall of 2011. Further discussion with the staff revealed the client had a goal to walk several days a week, however, more recently he had often refused to walk on the days the training was scheduled to be documented. Interview with the residential director (RD) on April 12, 2012, at 4:36 p.m. indicated that the client was encouraged to walk daily. Further discussion with the RD indicated that the client sometimes walked short distances in the facility, however, no record was maintained when he walked on a day of the week that did not require documentation of the ambulation.</p>	W 159	

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W 159.

Record review on April 11, 2012, at 3:12 p.m., revealed Client #2 had a physical therapy goal for August 13, 2011 through August 12, 2012, to increase his ambulation endurance skills. According to the objective, "Given stand by assistance, client will ambulate 100 feet" three days per week..." Review of the skill acquisition form revealed staff were to document the ambulation objective on three days a week. The data revealed that the client had refused to walk in March and April 2012 on the scheduled three days.

At the time of the survey, however, there was no evidence a system was in place to monitor if, and how far Client #2 walked on days not scheduled for documentation, to determine the extent of his overall progress toward the objective.

2. The QIDP failed to ensure a system was developed to monitor Client #2's progress toward his functional communication goal, as evidenced below:

On April 10, 2012, at 12:28 p.m., Client #2 was observed looking in the direction of his instructor in his class room as she verbally prompted him to participate in classroom activities. The client failed to respond to the instructor instructions after several verbal prompts.

On April 12, 2012, at 12:42 p.m., interview with the RD revealed that Client #2 had a recommendation to wear a hearing device to enhance his communication. Further discussion with the RD during this time revealed the hearing device was working properly, however, for some

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reason the client now refused to wear. The RD then brought the listen device to the surveyor and demonstrated how to operate it.

Record review on April 12, 2012, at 12:55 p.m., revealed Client #2's last audiology consultation, dated April 20, 2010, recommended that he wear an assistive listening device (amplifiers) when in the home. Continued record review revealed the client had a goal to increase his functional communication skills. According to the objective, "Given verbal prompts, the client will maintain his listening device appropriately for periods up to 25 minutes as measured by active treatment documentation. On April 12, 2012, at 1:17 p.m., review of the functional communication skill acquisition form revealed staff were to implement the program daily and to document the client's performance one time a week. On April 12, 2012, at 1:22 p.m., data collection revealed that the client participated with physical assistance in November 2011, and refused the listening device in December 2011 and January 2012. There was no evidence, however, that the QIDP monitored the client's performance in the objective during January 2012. At the time of the survey, the client continued to refuse to wear the device.

Further interview with the RD on April 12, 2012, at 4:36 p.m., indicated that Client #2 had occasionally accepted his listening device on days other than the days of scheduled documentation. The RD revealed, however, that the client's acceptance of the listening device on days other than those scheduled was not documented.

At the time of the survey, however, there was no

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evidence a system was developed to monitor the frequency that Client #2 used his listening device.

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W 331 483.460(c) NURSING SERVICES

W 331

The facility must provide clients with nursing services in accordance with their needs.

W331

This Standard will be met as evidenced by:

5/30/12

This STANDARD is not met as evidenced by:
Based on observation, staff interviews and record review, the facility's nursing staff failed to provide each client with services in accordance with their needs, for one of three clients in the sample. (Client #2)

The IDI's NP will train the RN, LPN and DSP's on the sign and symptoms of Edema and the use of TED stockings. The QDDP will order extra pairs of TED stockings for client #2. The QDDP will determine a location for the stockings so they can be easily located by staff.

The finding includes:

The facility's nursing services failed to ensure that Client #2's protocol was implemented to prevent and manage bilateral lower extremity edema, as evidenced below:

On April 10, 2012, at 7:52 a.m., Client #2 was observed seated in his wheelchair with his feet resting on the floor. He remained in his wheelchair until he was assisted to board the van to travel to his day program at 8:37 a.m. On the same day, from 12:25 p.m. to 1:10 p.m., the client was observed at his day program sitting in a regular chair with his feet resting on the floor. After arriving home from the day program, at 4:10 p.m., the client was again observed seated in his wheelchair with his feet resting on the floor. At 4:17 p.m., the client refused to stand or walk when staff verbally and physically prompted him to do so. Further observation of the client during the evening revealed the client sitting in his

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W 331 Continued From page 5

wheelchair in the living room at 4:53 p.m., and then in the dining room at 5:09 p.m. During the aforementioned times, the client was not observed to have his feet elevated.

On April 11, 2012, at 4:22 p.m., the surveyor observed that Client #2 was wearing short socks that left an indentation around his legs. The client's feet and ankles were observed to be swollen. LPN #2 assessed the client's lower extremities, confirmed the swelling, and requested that they be elevated. During this time, healed scars were also observed on the client's feet and ankles.

Interview with the residential (RD) on April 11, 2012, at 4:23 p.m., revealed that staff were to elevate the client's feet to prevent swelling of his lower extremities.

During the assessment of Client #2's feet on April 11, 2012, at 4:27 p.m., LPN #2 revealed that the client had a history of lower extremity edema. He further indicated that the scars on the client's feet were the result of open areas that developed from the fluid filled blisters. LPN #2 indicated that if the client's lower extremities were swollen, swelling would begin to subside when the client's feet are elevated.

Further observation of Client #2 on April 12, 2012, at 8:45 a.m., revealed he was seated in his wheelchair waiting to go to his day program. Minimal swelling of his lower extremities was observed during this time. When he returned from his day program at approximately 3:30 p.m., however, his lower extremities appeared more swollen than on April 11, 2012. At 3:47 p.m.,

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W 331	Continued From page 6 registered nurse (RN) #1 and LPN #1 were informed of the swelling. Upon assessment of the client, the RN determined that the client had 2+ edema of his legs and feet. The RN revealed that the client was prescribed to wear TED stockings as needed, if or when he had lower extremity edema. The RN and LPN #1 then put on the client's compression stockings. Continued discussion with the RN revealed that if staff observed that Client #2's lower extremities were swollen, they were to report the swelling to the nurse for assessment and appropriate intervention. If the nurse's assessment determined that the client had lower extremity edema, the as needed (prn) order for TED stockings was to be implemented. Interview with LPN #1 on April 12, 2012 at 3:47 p.m., indicated that Client #2's TED stockings were in his bedroom and she proceeded to search for them. When she was unable to locate them, she asked the staff, but they were unable to locate them. LPN #1 then left a telephone message for LPN #2 regarding the TED stockings. Upon his arrival to the facility at 4:00 p.m., LPN #2 located the client's TED stockings in the client's closet. The nurse was queried concerning any additional TED stockings, however, he indicated that no TED stockings were available for the client to be applied, if needed at his day program. At the time of the survey, there was no evidence a timely and effective system was implemented to ensure Client #2's legs were elevated to prevent edema, and to manage edema if and when it occurred.	W 331			
W 365	483.460(j)(4) DRUG REGIMEN REVIEW				

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W 365	<p>Continued From page 7</p> <p>An individual medication administration record must be maintained for each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medication records were accurately maintained for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>The facility's nursing services failed to ensure Client #3's prescribed medications had been documented accurately on the Medication Administration Records (MARs) according to the physicians' orders as evidenced below.</p> <p>1. During the morning medication administration on April 10, 2012, at approximately 7:40 a.m., Client #3 was observed to receive Fluoxetine HCL (Prozac) 40 mg capsule by mouth from licensed practical nurse #1 (LPN #1). Further observation confirmed the pharmacy had only dispensed a 30 day supply of Prozac 40 mg capsules to the facility which provided evidence the medication had been administered as ordered.</p> <p>Review of Client #3's physician's orders dated March 22, 2012, on April 10, 2012, at approximately 9:00 a.m., verified Client #3 was prescribed Prozac 40 mg capsule by mouth every day for depression. Review of Client #3's April 2012, Medication Administration Records (MARs) on April 10, 2012, at approximately 9:20 a.m., revealed LPN #1 had initialed the MAR at 8:00</p>	W 365	<p>W365</p> <p>This Standard will be met as evidenced by:</p> <p>1,2 The LPN's involved will receive corrective action for not properly documenting medication administration. LPN's for that home will be trained on Medication Administration and Documentation. The RN and NP will conduct random checks of MAR's and Physician Orders.</p>	6/15/12
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W 365	<p>Continued From page 8</p> <p>a.m. and 6:00 p.m., indicating Client #3 received Prozac 40 mg by mouth twice a day from April 1, 2012, through April 9, 2012. It should be noted that continued review of the client's MARs revealed LPN#1 had initialed the MARs indicating Client #3 had received Prozac 40 mg by mouth twice a day since January 2012.</p> <p>Interview with LPN #1 on April 10, 2012, at approximately 11:30 a.m., confirmed Client #3 was only receiving Prozac 40 mg by mouth once a day on the aforementioned dates. In a further interview with LPN #1 it was acknowledged that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MARs month after month, instead of verifying the MARs with the current physician's orders.</p> <p>2. During the morning medication administration on April 10, 2012, at approximately 7:42 a.m., Client #3 was observed to receive Docusate Sodium (Colace) Softgels 100 mg capsule by mouth from LPN #1. Further observation revealed the pharmacy had dispensed two bubble packs containing a 30 day supply of Colace 100 mg capsules each to the facility for administration morning and evening which provided evidence the medication had been administered as ordered.</p> <p>Review of Client #3's physician's orders dated April, 2012, on April 10, 2012, at approximately 9:50 a.m., verified Client #3 was prescribed Colace 100 mg capsule by mouth twice a day for constipation. Review of Client #3's April 2012, MAR on April 10, 2012, at approximately 9:55 a.m., revealed LPN #1 had initialed the MAR only</p>	W 365	

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at 6:00 p.m., indicating Client #3 received Colace 100 mg by mouth once a day from April 1, 2012, through April 10, 2012. It should be noted that continued review of the client's MARs revealed LPN#1 had initialed the MAR indicating Client #3 had received Colace 100 mg by mouth once a day at 6:00 p.m., since January 2012.

Interview with LPN #1 on April 10, 2012, at approximately 12:00 p.m., confirmed Client #3 was receiving Colace 100 mg by mouth once a day on the aforementioned dates. Further interview with LPN #1 it was acknowledged that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MAR month after month, instead of verifying the MAR with the current physician' orders.

W 365

W 368 483.460(k)(1) DRUG ADMINISTRATION

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that medications were administered in compliance with physicians' orders for one of three clients in the sample. (Client #3).

The findings include:

The facility's nursing services failed to ensure Client #3's prescribed medications had been documented accurately on the Medication Administration Records (MARs) according to the

W 368

W368

This Standard will be met as evidenced by:
1,2 The LPN's involved will receive corrective action for not properly documenting medication administration. LPN's for that home will be trained on Medication Administration and Documentation. The RN and NP will conduct random checks of MAR's and Physician Orders

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physicians' orders as evidenced below:

1. During morning medication administration on April 10, 2012, at approximately 7:40 a.m., Client #3 was observed to receive Fluoxetine HCL (Prozac) 40 mg capsule by mouth from licensed practical nurse #1 (LPN #1). Further observation confirmed the pharmacy had only dispensed a 30 day supply of Prozac 40 mg capsules to the facility which provided evidence the medication had been administrated as ordered.

Review of Client #3's physician's orders dated March 22, 2012, on April 10, 2012, at approximately 9:00 a.m., verified Client #3 was prescribed Prozac 40 mg capsule by mouth every day for depression. Review of Client #3's April 2012, MAR on April 10, 2012, at approximately 9:20 a.m., revealed LPN #1 had Initialed the MAR at 8:00 a.m. and 6:00 p.m., indicating Client #3 received Prozac 40 mg by mouth twice a day from April 1, 2012, through April 9, 2012. It should be noted that continued review of the client's MARs revealed LPN#1 had initialed the MARs indicating Client #3 had received Prozac 40 mg by mouth twice a day since January 2012.

Interview with LPN #1 on April 10, 2012, at approximately 11:30 a.m., confirmed Client #3 was only receiving Prozac 40 mg by mouth once a day on the aforementioned dates. Further interview with LPN #1 acknowledge that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MARs month after month, instead of verifying the MARs with the current physician' orders.

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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) COMPLETION DATE

W 368 . Continued From page 11

2. During the morning medication administration on April 10, 2012, at approximately 7:42 a.m., Client #3 was observed to receive Docusate Sodium (Colace) Softgels 100 mg capsule by mouth from LPN #1. Further observation revealed the pharmacy had dispensed two bubble packs containing a 30 day supply of Colace 100 mg capsules each to the facility for administration morning and evening which provided evidence the medication had been administered as ordered.

Review of Client #3's physician's orders dated April, 2012, on April 10, 2012, at approximately 9:50 a.m., verified Resident #3 was prescribed Colace 100 mg capsule by mouth twice a day for constipation. Review of Resident #3's April 2012, MAR on April 10, 2012, at approximately 9:55 a.m., revealed LPN #1 had initialed the MAR only at 6:00 p.m., indicating Client #3 received Colace 100 mg by mouth once a day from April 1, 2012, through April 10, 2012. It should be noted that continued review of the client's MAR revealed LPN#1 had initialed the MAR indicating Client #3 had received Colace 100 mg by mouth once a day at 6:00 p.m., since January 2012.

Interview with LPN #1 on April 10, 2012, at approximately 12:00 p.m., confirmed Client #3 was receiving Colace 100 mg by mouth once a day on the aforementioned dates. In a further interview with LPN #1 it was acknowledged that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MAR month after month, instead of verifying the MAR with the current physician's orders.

W 368.

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

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032	
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W 368	Continued From page 12 There was no documented evidence that all medications were administered in compliance with physicians' orders.	W 368	
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to remove from use drug containers with worn, illegible or missing labels for two of the five clients in the facility. [Client #2 and Client #5] The findings include: 1. On April 12, 2012, at approximately 7:30 a.m., licensed practical nurse (LPN) #2 was observed removing a bottle of Docu Liquid 50 mg/5 ml from the medication cabinet. Further observation revealed the aforementioned medication bottle had a worn pharmacy label that was torn in places. During a face to face interview with LPN #2 on April 12, 2011, at approximately 7:32 a.m., it was acknowledged Client #2 was prescribed Docu Liquid 5 ml every day by mouth and that the aforementioned medication pharmacy label was worn and torn in places. Further interview revealed the LPN would call the pharmacy to replace the bottle of Docu Liquid. Review of Client #2's April Medication Administration Record (MAR) and physician order sheet (POS) dated April, 2012, on April 12, 2012, at approximately 7:33 a.m. confirmed Client #2 was prescribed the aforementioned medication for constipation.	W 391	4/20/12 W391 This Standard will be met as evidenced by: 1,2 the LPN will call the pharmacy to replace all medications indicated with worn and torn labels. The RN and LPN, will set up a schedule to periodically check the condition of the labels on all the Individuals medications. RN Supervisor and LPN will ensure ongoing compliance with this standard during the monthly Grand Round and on an ongoing basis.

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W 391 Continued From page 13
2. On April 12, 2012, at approximately 8:01 a.m., LPN #2 was observed removing a bottle of Lactulose from the medication cabinet. Further observation revealed the aforementioned medication bottle had a torn pharmacy label that was worn and illegible in places. During a face to face interview with the LPN #2 on April 12, 2011, at approximately 8:02 a.m., it was acknowledged Client #5 was prescribed Lactulose 5 ml every day by mouth and the aforementioned medication pharmacy label was torn and illegible in places. Further interview revealed the LPN would call the pharmacy to replace the bottle of Lactulose. Review of Client #5's April MAR and physician order POS dated April, 2012, on April 12, 2012, at approximately 8:03 a.m. confirmed Client #5 was prescribed the aforementioned medication for constipation.

W 391

There was no observable evidence the facility ensured that all prescribed medications did not have worn and torn pharmacy labels.

W 436: 483.470(g)(2) SPACE AND EQUIPMENT

The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that recommended assistive devices were maintained in good repair for three of three clients in the

W 436

W436
This Standard will be met as evidenced by:
The shower gurney will be replaced. The QDDP and Residential Director will receive additional training on Adaptive Equipment repairs and maintenance from the Director of Residential Services (DRS). The QDDP and RD will follow and implement the established adaptive equipment protocol to ensure that adaptive equipment is maintained in good condition at all times.

5/30/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 436 Continued From page 14
sample. (Clients #1, #2, and #3)

W 436

The findings include:

The facility failed to ensure that the shower gurney mat was maintained in good condition, as evidenced below:

On April 12, 2012, at 3:35 p.m., multiple cracks were observed in the mat attached to the shower gurney. The cracks permitted water to enter the foam padding underneath the vinyl covering. The residential director (RD) and the qualified intellectual disabilities professional (QIDP) were present during the observation.

On April 12, 2012, at 3:39 p.m., interview with the RD and the QIDP revealed the mat was used on the shower gurney for bathing of the clients. Further discussion with the RD and the QIDP confirmed that the shower gurney mat needed to be replaced due to the observed cracks.

At the time of the survey, there was no evidence the facility to maintained the shower gurney mat to ensure it was free of torn areas, to prevent the entrance of water into the cracks when in use.

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032
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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
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1000 INITIAL COMMENTS

1000

A licensure survey was conducted from April 10, 2012 through April 12, 2012. A sample of three residents was selected from a population of six men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at one day programs, interview with one client's guardian, staff at the home and at the one day programs, as well as a review of client and administrative records, including incident reports.

(Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.)

1090 3504.1 HOUSEKEEPING

1090

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in a sanitary manner for three of three residents in the sample. (Residents #1, #2, and #3)

The findings include:

The facility failed to ensure that the shower gurney mat was maintained in good condition, as evidenced below:

1090

This Statute will be met as evidenced by:

The shower gurney will be replaced. The QDDP and Residential Director will receive additional training on Adaptive Equipment repairs and maintenance from the Director of Residential Services (DRS). The QDDP and RD will follow and implement the established adaptive equipment protocol to ensure that adaptive equipment is maintained in good condition at all times.

S/30/12

Health Regulation & Licensing Administration

Jeffrey H. Semler Director of Residential Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE S/11/12

(X6) DATE

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1090 Continued From page 1

1090

On April 12, 2012, at 3:35 p.m., multiple cracks were observed in the mat attached to the shower gurney. The cracks permitted water to enter the foam padding underneath the vinyl covering. The residential director (RD) and the qualified intellectual disabilities professional (QIDP) were present during the observation.

On April 12, 2012, at 3:39 p.m., interview with the RD and the QIDP revealed the mat was used on the shower gurney for bathing of the residents. Further discussion with the RD and the QIDP confirmed that the shower gurney mat needed to be replaced due to the observed cracks.

At the time of the survey, there was no evidence the facility to maintained the shower gurney mat to ensure it was free of torn areas, to prevent the entrance of water into the cracks when in use.

1180 3508.1 ADMINISTRATIVE SUPPORT

1180

Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

This Statute is not met as evidenced by: Based on observation, interview and record verification, the group home for persons with intellectual disabilities (GHPID) failed to provide adequate administrative support to efficiently meet the needs of the residents in accordance with the habilitation plans, for one of three residents in the sample. (Resident #2)

The findings include:

1. The QIDP failed to ensure a system developed

1180

S/30/12

This Statute will be met as evidenced by:

1. QDDP will coordinate with PT to revise Client #2 PT goal. The PT goal will address the need for the staff to measure how far Client#2 walked. Staff will be retrained on any revisions to the goal.
2. A new evaluation should be scheduled to determine the appropriateness of the amplifier given that Client #2 at times refuses to use it. After the evaluation, the QDDP will ensure that the communication goal is implemented as written

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I 180 Continued From page 2

I 180

to monitor Resident #2's progress toward his ambulation goal, as evidenced below.

On April 10, 2012, at 12:28 p.m., Resident #2 was observed seated in a regular chair at a table in a treatment room with his peers. Interview with the day program instructor on the same day at approximately 12:35 p.m., revealed that Resident #2 was encouraged to sit in regular chairs, and sometimes the recliner at his day program. The day program instructor also indicated that the resident was encouraged to walk short distances, to use his wheelchair for distance travel, and to use his wheelchair for safety, if he refused to walk. The instructor stated the resident walked more in the past. However, after returning to day treatment from an extended medical absence (fall of 2011), the resident did not want to walk much.

On April 10, 2012, at 4:17 p.m., direct support staff #1 asked Resident #2, "Let's go for a walk?" The resident responded by saying, "Nope, nope, nope" repeatedly, then refused to stand up with assistance of staff using his gait belt. Staff indicated that it was sometimes very difficult to get the resident to walk and that his ambulation skills had declined after his illness during the fall of 2011. Further discussion with the staff revealed the resident had a goal to walk several days a week, however, more recently he had often refused to walk on the days the training was scheduled to be documented. Interview with the residential director (RD) on April 12, 2012, at 4:36 p.m. indicated that the resident was encouraged to walk daily. Further discussion with the RD indicated that the resident sometimes walked short distances in the facility, however, no record was maintained when he walked on a day of the week that did not require documentation of the ambulation.

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1180	<p>Continued From page 3</p> <p>Record review on April 11, 2012, at 3:12 p.m., revealed Resident #2 had a physical therapy goal for August 13, 2011 through August 12, 2012, to increase his ambulation endurance skills. According to the objective, "Given stand by assistance, resident will ambulate 100 feet" three days per week..." Review of the skill acquisition form revealed staff were to document the ambulation objective on three days a week. The data revealed that the resident had refused to walk in March and April 2012 on the scheduled three days.</p> <p>At the time of the survey, however, there was no evidence a system was in place to monitor if, and how far Resident #2 walked on days not scheduled for documentation, to determine the extent of his overall progress toward the objective.</p> <p>2. The QIDP failed to ensure a system was developed to monitor Resident #2's progress toward his functional communication goal, as evidenced below:</p> <p>On April 10, 2012, at 12:28 p.m., Resident #2 was observed looking in the direction of his instructor in his class room as she verbally prompted him to participate in classroom activities. The resident failed to respond to the instructor instructions after several verbal prompts.</p> <p>On April 12, 2012, at 12:42 p.m., interview with the RD revealed that Resident #2 had a recommendation to wear a hearing device to enhance his communication. Further discussion with the RD during this time revealed the hearing device was working properly, however, for some reason the resident now refused to wear. The</p>	1180	

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I 180	Continued From page 4 RD then brought the listen device to the surveyor and demonstrated how to operate it. Record review on April 12, 2012, at 12:55 p.m., revealed Resident #2's last audiology consultation, dated April 20, 2010, recommended that he wear an assistive listening device (amplifiers) when in the home. Continued record review revealed the resident had a goal to increase his functional communication skills. According to the objective, "Given verbal prompts, the resident will maintain his listening device appropriately for periods up to 25 minutes as measured by active treatment documentation. On April 12, 2012, at 1:17 p.m., review of the functional communication skill acquisition form revealed staff were to implement the program daily and to document the resident's performance one time a week. On April 12, 2012, at 1:22 p.m., data collection revealed that the resident participated with physical assistance in November 2011, and refused the listening device in December 2011 and January 2012. There was no evidence, however, that the QIDP monitored the resident's performance in the objective during January 2012. At the time of the survey, the resident continued to refuse to wear the device. Further interview with the RD on April 12, 2012, at 4:36 p.m., indicated that Resident #2 had occasionally accepted his listening device on days other than the days of scheduled documentation. The RD revealed, however, that the resident's acceptance of the listening device on days other than those scheduled was not documented. At the time of the survey, however, there was no evidence a system was developed to monitor the frequency that Resident #2 used his listening	I 180		

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I 180	Continued From page 5 device.	I 180	
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure an annual health certificate were available for two of twelve consultants. (Consultants #1 and #2)</p> <p>The findings include:</p> <p>During the entrance conference on April 10, 2012, at 9:10 a.m., the qualified intellectual disabilities professional (QIDP) was requested to obtain and provide the current health certificates for the staff and consultants for review. Interview with the QIDP on April 10, 2012, at 9: 22 a.m., revealed that the health certificates would be available for review on April 11, 2012.</p> <p>On April 12, 2012, at 5:15 p.m., the review of the provided records revealed that no health certificates were available for Consultants #1 and #2.</p> <p>Interview with the residential director on April 12, 2012, at 5:19 p.m., confirmed that the aforementioned health certificates were not</p>	I 206	<p>I206 This Statute will be met as evidenced by: The health certificate has been obtained for Consultants #1 and #2. In the future, IDI will continue to track expiration of consultants health certificates.</p> <p>4/20/12</p>

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1206	Continued From page 6 provided for review.	1206	
1223	<p>3510.4 STAFF TRAINING</p> <p>Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that each program agenda and record of staff participation was maintained in the facility and available for review by the Department of Health (DOH).</p> <p>The findings include:</p> <p>During the entrance conference on April 10, 2012, at 9:10 a.m., the qualified intellectual disabilities professional (QIDP) was requested to provide staff training records for review. Interview with the QIDP on April 10, 2012, at 9:22 a.m., revealed that the training records would be available for review on April 11, 2012.</p> <p>On April 12, 2012, at 3:19 p.m., record review revealed incomplete training records, as evidenced below:</p> <ul style="list-style-type: none"> a. One of six sign in forms, entitled PT (physical therapy) revealed it lacked the date and time of the training. The form also did not include an agenda. b. Two of six sign in forms, entitled PT (physical therapy) did not include agendas. c. One of six sign in forms lacked the title of the session and agenda. 	1223	<p>1223</p> <p>This Statute will be met as evidenced by:</p> <p>IDI QDDP's will be retrained on the preparation of staff training records. IDI's Training Director will periodically audit staff training files.</p> <p style="text-align: right;">5/30/12</p>

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I 223	Continued From page 7 d. One of six sign in forms lacked a title of session, date, time, location, or agenda. The form was noted to contain only signatures of the staff and the facilitator. e. One of six sign in forms lacked the title of the session or an agenda. Further interview with the QIDP on April 12, 2012, at 5:30 p.m., confirmed that the aforementioned training records were incomplete, and lacked agendas of the information provided during the sessions.	I 223		
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, staff interviews and record review, the group home for persons with intellectual disabilities (GHPID) provided professional services in accordance with the needs of one of three residents in the sample. (Resident #2) The finding includes: The facility's nursing services failed to ensure that Resident #2's protocol was implemented to prevent and manage bilateral lower extremity edema, as evidenced below:	I 401	I401 This Statute will be met as evidenced by: The IDI's NP will train the RN, LPN and DSP's on the sign and symptoms of Edema. The QDDP will order extra pairs of TED stockings for client #2. The QDDP will determine a location for the stockings so they can be easily located by staff.	5/30/12

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I 401	Continued From page 8 On April 10, 2012, at 7:52 a.m., Resident #2 was observed seated in his wheelchair with his feet resting on the floor. He remained in his wheelchair until he was assisted to board the van to travel to his day program at 8:37 a.m. On the same day, from 12:25 p.m. to 1:10 p.m., the resident was observed at his day program sitting in a regular chair with his feet resting on the floor. After arriving home from the day program, at 4:10 p.m., the resident was again observed seated in his wheelchair with his feet resting on the floor. At 4:17 p.m., the resident refused to stand or walk when staff verbally and physically prompted him to do so. Further observation of the resident during the evening revealed the resident sitting in his wheelchair in the living room at 4:53 p.m., and then in the dining room at 5:09 p.m. During the aforementioned times, the resident was not observed to have his feet elevated. On April 11, 2012, at 4:22 p.m., the surveyor observed that Resident #2 was wearing short socks that left an indentation around his legs. The resident's feet and ankles were observed to be swollen. LPN #2 assessed the resident's lower extremities, confirmed the swelling, and requested that they be elevated. During this time, healed scars were also observed on the resident's feet and ankles. Interview with the residential (RD) on April 11, 2012, at 4:23 p.m., revealed that staff were to elevate the resident's feet to prevent swelling of his lower extremities. During the assessment of Resident #2's feet on April 11, 2012, at 4:27 p.m., LPN #2 revealed that the resident had a history of lower extremity edema. He further indicated that the scars on the resident's feet were the result of open areas that	I 401			

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I 401	<p>Continued From page 9</p> <p>developed from the fluid filled blisters. LPN #2 indicated that if the resident's lower extremities were swollen, swelling would begin to subside when the resident's feet are elevated.</p> <p>Further observation of Resident #2 on April 12, 2012, at 8:45 a.m., revealed he was seated in his wheelchair waiting to go to his day program. Minimal swelling of his lower extremities was observed during this time. When he returned from his day program at approximately 3:30 p.m., however, his lower extremities appeared more swollen than on April 11, 2012. At 3:47 p.m., registered nurse (RN) #1 and LPN #1 were informed of the swelling. Upon assessment of the resident, the RN determined that the resident had 2+ edema of his legs and feet. The RN revealed that the resident was prescribed to wear TED stockings as needed, if or when he had lower extremity edema. The RN and LPN #1 then put on the resident's compression stockings. Continued discussion with the RN revealed that if staff observed that Resident #2's lower extremities were swollen, they were to report the swelling to the nurse for assessment and appropriate intervention. If the nurse's assessment determined that the resident had lower extremity edema, the as needed (prn) order for TED stockings was to be implemented.</p> <p>Interview with LPN #1 on April 12, 2012 at 3:47 p.m., indicated that Resident #2's TED stockings were in his bedroom and she proceeded to search for them. When she was unable to locate them, she asked the staff, but they was unable to locate them. LPN #1 then left a telephone message for LPN #2 regarding the TED stockings. Upon his arrival to the facility at 4:00 p.m., LPN #2 located the resident's TED stockings in the resident's closet. The nurse was</p>	I 401	

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I 401	Continued From page 10 queried concerning any additional TED stockings, however, he indicated that no TED stockings were available for the resident to be applied, if needed at his day program.	I 401	
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, interview and record verification, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to report irregularities to the Primary Care Physician (PCP) for one of three residents included in the sample. (Resident #3) The findings include: 1. During the morning medication administration on April 10, 2012, at approximately 7:42 a.m., Resident #3 was observed to receive Docusate Sodium (Colace) Softgels 100 mg capsule by mouth from licensed practical nurse #2 (LPN #2). Review of Resident #3's physician's orders dated August 23, 2011, on April 10, 2012, at approximately 9:58 a.m., revealed an order to discontinue Docusate (Colace) Liquid 30 ml every day. Review of Resident #3's August 2011, Medication Administration Record (MAR) on April 10, 2012, at approximately 10:00 a.m., revealed Colace Liquid 30 ml every day was not discontinued until August 25, 2011 (2 days later). Interview with LPN #1 on April 10, 2012, at approximately 12:00 p.m., confirmed Resident #3's Colace Liquid 30 ml every day was not discontinued on the August MAR until August 25,	I 473	I473 This Statute will be met as evidenced by: 1,2,3&4 The LPN's involved will receive corrective action for not properly documenting medication administration. LPN's for that home will be trained on Medication Administration and Documentation. The RN and NP will conduct random checks of MAR's and Physician Orders for accuracy. All IDI's nursing staff is expected to report any irregularities in the Individual's medication regimen to the PCP. 5/15/12

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1473	Continued From page 11 2011. Further interview with LPN #2 revealed that the medication was not discontinued until August 25, 2011, because he believed the pharmacy was unable to deliver the Colace 100 mg capsule until that day. 2. Review of Resident #3's August 2011, MARs on April 10, 2012, at approximately 10:00 a.m., revealed an order to start Colace 100 mg capsule by mouth twice a day for constipation on August 23, 2011. Further review revealed Colace 100 mg capsule was not administered until August 25, 2011, at 6:00 p.m. Interview with LPN #1 on April 10, 2012, at approximately 12:10 p.m., confirmed Resident #3's Colace 100 mg capsule was not administered until August 25, 2011, at 6:00 p.m. 3. Review of Resident #3's September 2011 MARs on April 10, 2012, at approximately 12:15 p.m., revealed LPN #2 had initialed the MAR at 6:00 p.m., indicating Resident #3 received Colace Liquid 30 ml by mouth once a day at 6:00 p.m., from September 2011 through December 2011. Further review of the September 2011 MAR revealed Colace 100 mg capsule twice a day was not transcribed on the September 2011 MAR. Interview with LPN #1 on April 10, 2012, at approximately 12:20 p.m., confirmed Resident #3 received Colace Liquid 30 ml by mouth once a day at 6:00 p.m., from September 2011 through December 2011 and that Colace 100 mg capsule twice a day was not transcribed on the September 2011 MAR. 4. Review of Resident #3's October 2011 MAR on April 10, 2012, at approximately 12:20 p.m., revealed LPN #2 had initialed the MAR at 6:00 p.m., indicating Resident #3 received Colace Liquid 30 ml by mouth. The nurse additionally initialed the MAR at 8:00 a.m. and 6:00 p.m.,	1473		

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I 473	Continued From page 12 Indicating Resident #3 also received Colace 100 mg Capsule from October 2011 through December 2011. During an interview with LPN #1 on April 10, 2012, at approximately 12:25 p.m., it was confirmed that Colace Liquid 30 ml by mouth once a day at 6:00 p.m., was initialed as administered from October 2011 through December 2011 along with Colace 100 mg capsule twice a day. Interview with LPN #1 on April 10, 2012, at approximately 12:40 p.m., however revealed she denies actually administering Colace Liquid 30 ml by mouth on the aforementioned dates. During an interview with LPN #1 and LPN #2 on April 10, 2012, at approximately 1:15 p.m., it was acknowledged that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MAR month after month, instead of verifying the MAR with the current physician' orders. Further interview with LPN #1 and LPN #2 revealed the Primary Care Physician (PCP) was not made aware of the drug irregularities. There was no documented evidence the irregularities were reported were reported to the PCP.	I 473		
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review the Group Home for Person's with Intellectual Disabilities' (GHPID) nursing staff failed to maintain the	I 474	I474 This Statute will be met as evidenced by: 1,2 The LPN's involved will receive corrective action for not properly documenting medication administration. LPN's for that home will be trained on Medication Administration and Documentation. The RN and NP will conduct random checks of MAR's and Physician Orders for accuracy.	5/15/12

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I 474	Continued From page 13 Medication Administration Record (MAR) for one of one resident in the sample. (Resident #3) The findings include: The facility's nursing services failed to ensure Resident #3's prescribed medications had been documented accurately on the Medication Administration Records (MARs) according to the physicians' orders as evidenced below. 1. During morning medication administration on April 10, 2012, at approximately 7:40 a.m., Resident #3 was observed to receive Fluoxetine HCL (Prozac) 40 mg capsule by mouth from licensed practical nurse #2 (LPN #2). Further observation confirmed the pharmacy had only dispensed a 30 day supply of Prozac 40 mg capsules to the facility which provided evidence the medication had been administrated as ordered. Review of Resident #3's physician's orders dated March 22, 2012, on April 10, 2012, at approximately 9:00 a.m., verified Resident #3 was prescribed Prozac 40 mg capsule by mouth every day for depression. Review of Resident #3's April 2012, MAR on April 10, 2012, at approximately 9:20 a.m., revealed LPN #2 had initialed the MAR at 8:00 a.m. and 8:00 p.m., indicating Resident #3 received Prozac 40 mg by mouth twice a day from April 1, 2012, through April 9, 2012. It should be noted that continued review of the client's MAR revealed LPN #2 had initialed the MAR indicating Resident #3 had received Prozac 40 mg by mouth twice a day since January 2012. Interview with LPN #1 on April 10, 2012, at	I 474			

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I 474	Continued From page 14 approximately 11:30 a.m., confirmed Resident #3 was only receiving Prozac 40 mg by mouth once a day on the aforementioned dates. Further interview with LPN #1 acknowledge that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MARs month after month, instead of verifying the MAR with the current physician's orders. 2. During the morning medication administration on April 10, 2012, at approximately 7:42 a.m., Resident #3 was observed to receive Docusate Sodium (Colace) Softgels 100 mg capsule by mouth from LPN #2. Further observation revealed the pharmacy had dispensed two bubble packs containing a 30 day supply of Colace 100 mg capsules each to the facility for administration morning and evening which provided evidence the medication had been administrated as ordered. Review of Resident #3's physician's orders dated April, 2012, on April 10, 2012, at approximately 9:50 a.m., verified Resident #3 was prescribed Colace 100 mg capsule by mouth twice a day for constipation. Review of Resident #3's April 2012, MAR on April 10, 2012, at approximately 9:55 a.m., revealed LPN #2 had initialed the MAR only at 6:00 p.m., indicating Resident #3 received Colace 100 mg by mouth once a day from April 1, 2012, through April 10, 2012. It should be noted that continued review of the client's MARs revealed LPN #2 had initialed the MAR indicating Resident #3 had received Colace 100 mg by mouth once a day at 6:00 p.m., since January 2012. Interview with LPN #1 on April 10, 2012, at approximately 12:00 p.m., confirmed Resident #3	I 474		

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I 474	Continued From page 15 was receiving Colace 100 mg by mouth once a day on the aforementioned dates. In a further interview with LPN #1 it was acknowledged that documentation errors had been made as a result of reviewing and copying what was already documented on the previous MAR month after month, instead of verifying the MAR with the current physician' orders.	I 474		
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 and interview, the group home for persons with intellectual disabilities' (GHPID) nursing staff failed to remove from it's use, medications that had worn or missing label for two of five residents residing in the facility. (Residents #2 and #5) The findings include: 1. On April 10, 2012, at approximately 7:30 a.m., the licensed practical nurse (LPN) was observed removing a bottle of Docu Liquid 50 mg/5 ml from the medication cabinet. Further observation revealed the aforementioned medication bottle had a worn pharmacy label that was torn in places. During a face to face interview with the LPN #2 on April 10, 2011, at approximately 7:32 a.m., it was acknowledged Resident #2 was prescribed Docu Liquid 5 ml every day by mouth and that the aforementioned medication pharmacy label was worn and torn in places. Further interview revealed the LPN would call the pharmacy to replace the bottle of Docu Liquid.	I 484	I484 This Statute will be met as evidenced by: 1,2, the LPN will call the pharmacy to replace all medications indicated with worn and torn labels. The RN and LPN, will set up a schedule to periodically check the condition of the labels on all the Individuals medications. RN Supervisor and LPN will ensure ongoing compliance with this standard during the monthly Grand Round and on an ongoing basis.	4/20/12

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I 484	Continued From page 16 Review of Resident #2's April Medication Administration Record (MAR) and physician order sheet (POS) dated April, 2012, on April 10, 2012, at approximately 7:33 a.m. confirmed Resident #2 was prescribed the aforementioned medication for constipation. 2. On April 10, 2012, at approximately 8:01 a.m., LPN #1 was observed removing a bottle of Lactulose from the medication cabinet. Further observation revealed the aforementioned medication bottle had a torn pharmacy label that was worn and illegible in places. During a face to face interview with LPN #1 on April 10, 2011, at approximately 8:02 a.m., it was acknowledged Resident #5 was prescribed Lactulose 5 ml every day by mouth and the aforementioned medication pharmacy label was torn and illegible in places. Further interview revealed LPN #1 would call the pharmacy to replace the bottle of Lactulose. Review of Resident #5's April MAR and physicians' orders (POS) dated April 2012, on April 10, 2012, at approximately 8:03 a.m. confirmed Resident #5 was prescribed the aforementioned medication for constipation. There was no observable evidence the facility ensured that all prescribed medications did not have worn and torn pharmacy labels.	I 484		