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

PRINTED: 04/08/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G120		11/20/2008

NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE: 2620 24TH STREET, NE, WASHINGTON, DC 20018

(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 This recertification survey was conducted from November 16, 2008 through November 20, 2008. The survey was initiated using the fundamental survey process. Six female clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	W 000	Receiving 4/9/09	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to ensure the proper implementation of meal time feeding protocols and failed to ensure proper infection control measures for two of three sampled clients. [Clients #1 and #2] The finding includes: 1. Observation at 11:42am on 11/19/2008 at Client #1 's day program revealed the attending staff failed to ensure half of her meal was properly stored, failed to ensure that she received her liquids in a nectar consistency and failed to ensure that she be afforded sips of beverage	W 120	W120 This Standard will be met as evidenced by: Facility personnel, Direct Care Staff and nurse has provided detail trainings to the day program staff in regards to mealtime protocol, feeding techniques, adaptive feeding equipment for client #1 and proper way to dress and managed client #2's G-Tube. Facility management will continue on-going monitoring at the day program site to ensure compliance with the training as provided.	11/25/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADRS DATE: 4/9/09

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 120	Continued From page 1 between the servings of her pureed solids as required in her mealtime feeding protocol. [See W474 and Reference W476] 2. Observation at 12:01pm on 11/19/2008 at Client #2 ' s day program revealed, she was allowed to sit in the main room listening to music after lunch. Staff onsite at the time of the observation indicated that this was what they usually allowed her to do after lunch... as common practice. Further observation revealed the left side of Client #2 ' s shirt was lifted and her G-Tube was left exposed and unsecured as she sat listening to the music. The staff onsite at the time of the observation was not able to explain why her G-Tube was allowed to remain exposed. [See W331]	W 120		
W 189	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, staff interview and record review, the facility failed to ensure that staff was effectively trained in implementing a client ' s meal time feeding protocol for one of three sampled clients. [Client #1] The finding includes: [Cross Reference W474] Observation on 11/19/2008 at 11:42am revealed staff at Client #1 ' s day program failed to serve liquids at the proper consistency, failed to ensure	W 189	**W189** **This Standard will be met as evidenced by:** OK **Cross reference W120** In addition, the home management and nurse has visited the day program at different time and provided on-site review and mealtime monitoring to ensure that client #1 is receiving her food in accordance with protocol as established and ordered by her physician. Home management will continue period monitoring to ensure compliance with the training as outlined.	11/25/08

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W 212	Continued From page 3 s health and well-being for one of three sampled clients. [Client #1] The findings include: Observation during the survey between the dates of 11/18/2008 and 11/20/2008 revealed Client #1's medical diagnoses included cerebral palsy, kyphoscoliosis, mild contractures, spastic diplegia and she required a custom molded seat and had little to no control over her gross motor functioning. Client #1 generally sits in her molded wheelchair with her upper torso curved and leaning to the left with her head resting on her left shoulder. During the survey, this client ' s head was never observed resting in the supportive head rest that ' s attached to her wheelchair. Her head was always observed resting on her left shoulder. With that observation, the only time staff " aligned " Client #1 ' s head into a " 90 degree " position was when she was being fed. Staff interview at the home on 11/18/2008 at 5:22pm revealed they feel she prefers to have her head rest on her left shoulder as this was the most comfortable position for her to be in. Client #1 ' s Physical Therapy assessment dated 7/2/2008 indicated Client #1 was assessed with the following: § Client #1 ' s head/neck is " aligned ". § Client #1 ' s shoulders are " level ". The assessment further provides the following intervention: § Goal: To improve posture. § Objective: [Client #1] will tolerate right and left	W 212	**W212** **This Standard will be met as evidenced by:** **Cross reference W104 #1 &2** .Client #1 received a new wheelchair on 3/6/09. And as previously mentioned, client #1 generally places her head to the left side as a position of comfort. The D.O.N has corrected the error on the current HMCP. In addition, the PT has indicated in her quarterly notes that the left side is a position of comfort and that every time someone has attempt to change that position, she continue to revert her head to her shoulder. Staff will continue to receive on-going training on client #1 positioning. OK	11/25/08

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W 212	Continued From page 4 sideline positioning and supine positioning for minimal 30 minutes daily for 12 consecutive months. It was not clear how the objective of employing " left sideline positioning " addressed the correction of the client ' s posture, when Client #1 generally rests her head on her left shoulder. It was also not clear why Client #1 ' s Health Management Care Plan indicated that her Kyphoscoliosis was due to poor positioning. Interview with the facility ' s Acting Qualified Mental Retardation Professional (QMRP) on 11/19/2008 at 2:21pm revealed this assessment was made in error. There was no evidence on file at the time of survey to substantiate that this client ' s head lean was accurately assessed and that effective programmatic or habilitative efforts were being undertaken to address her poor posture with regards to her head alignment.	W 212		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE 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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC) for two of six clients residing in the facility. (Clients #2 and #4) The findings include:	W 262		

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W 262	Continued From page 5 1. Interview with the facility's designated Licensed Practical Nurse (LPN) and review of Client #2's medical records on November 20, 2008 at approximately 12:15 PM revealed the client received sedation (Chloral Hydrate 15 ml) via G-tube prior to her gynecology appointment on November 30, 2007. Interview with the Assistant Director of Residential Services (ADRS) on the same day at approximately 1:00 PM revealed that HRC had approved the use of sedation for Client #2's gyn appointment. Review of the HRC minutes on November 19 and 20, 2008 failed to provide evidence that use of sedation was reviewed and approved by the HRC prior to it's use. 2. Interview with the facility's LPN on November 20, 2008 at approximately 1:10 PM revealed that Client #4 had received the following sedation for medical appointments: 2/29/08 - Chloral Hydrate 15 ml via G-tube one hour prior to ENT appointment. 5/14/08 - Chloral Hydrate 15 ml vial G-tube one hour prior to Audiology appointment. 9/4/08 - Activa 2 mg one hour prior to Gyn appointment. 10/28/08 - Ativan 2 mg one hour prior to Ophthalmology appointment. Review of the facility's HRC policy was reviewed on November 20, 2008 at approximately 1:30 PM. According the the policy, the HRC was to "review, approve, monitor individual behavior support plans/interventions that may involve risks to the individual's protection, and restriction to rights."	W 262	W262 This Standard will be met as evidenced by: QMRP and the facility nurse will ensure that all restrictive control medication use for sedation are reviewed by the Human Rights Committee And that the team discuss risks and treatment therapy, intended outcome, benefits and possible side effects. Clients will continue to be involved in the process to the extent of their ability to understand. ok	12/18/08

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W 262	Continued From page 6 At the time of the survey, there was no evidence that the HRC meeting had been conducted to review and approve the use of the sedations.	W 262		
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 subsequent record review, the facility failed to ensure that each client's medications was administered as written for one of two sampled clients. [Client #5] The findings include: Observation on the evening of 11/18/2008 at 6:22pm revealed Client #5 received her evening medication and was provided her evening serving of Isosource right afterwards. The nurse failed to provide the " 20cc flush " as recommended by her Tube Feeding Protocol as dated on 7/20/2008. Additional record review revealed, Client #5's Physician Order Sheet dated 9/2008 detailed that the nursing staff should "flush G-Tube with... 20ml of water before and after each med pass". Interview with the facility's Nurse on 11/18/2008 at 3:45pm revealed the evening medication should have been flushed with 20cc before providing Client #5 with her evening feeding.	W 369	W369 **This Standard will be met as evidenced by:** The D.O.N has provided additional training to all nurses on nursing protocols that included G-Tube feeding protocol. RN will continue on-going training and monitoring of protocols/practices to ensure compliance as set forth. GK	11/20/06
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team	W 371		

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W 371	Continued From page 7 determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interview and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for one of three clients in the sample. (Client #3) The finding includes: Observations of the evening medication administration on November 18, 2008 at 7:11 PM revealed Client #3 was administered Norvasc 5 mg, Metformin 500 mg, Omeparazole 20 mg, and Diclofenac sodium 75 mg by mouth by the Licensed Practical Nurse (LPN). The LPN was observed to punch the medications into the cup and prepare the water for Client #3. She was further observed to place the medication cup and water on a small table in Client #3's bedroom. Client #3 consumed the medications and water independently without spillage. Interview with the LPN after the medication pass at approximately 7:19 PM revealed that Client #3 was not on a self medication program. Review of Client #3's self medication assessment dated October 1, 2008 on November 19, 2008 at approximately 2:50 PM revealed the following strengths: - Discriminate primary colors - Identify printed or typed name from group of three - Responds correctly to simple direction	W 371	W371 This Standard will be met as evidenced by: QMRP has reassessed client #3 for self medication and a program has been written to ensure client #3 full participation during medication pass. As part of compliance with the medication procedure, nursing staff will document daily on client #3's participation during med pass. OK	11/25/08

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W 371	Continued From page 8 - Correctly indicate times (s) of day when medications are given -Takes medication with one prompt Further review of the assessment revealed that the client was not approved for a self medication program. The reason indicated that the client was already participating with medication administration. Interview with the facility's designated LPN on November 19, 2008 at 3:29 PM revealed that Client #3 could punch medications into the cup, retrieve her medications, and tell time of day when medications are given. At the time of the survey, there was no evidence that the client was given the opportunity to participate in a self-medication program.	W 371		
W 474	483.460(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client's received their meal(s) in the form and consistency as required for one of three sampled clients. (Client #1) The findings include: Observation on 11/19/2008 at 11:42am at Client #1 ' s day program revealed the staff served Client #1 her pureed serving of mashed potatoes with the Nozzle Feeder and then poured approximately 3-4 oz of water in the Nozzle Feeder right afterwards and then served that	W 474		

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W 474	Continued From page 9 mixture to her. She then took the Nozzle Feeder to the kitchen and washed it. The staff then returned to the table and served Client #1 her pureed serving of mixed vegetables and poured another 3-4oz of water into the Nozzle Feeder and served that mixture to her as well. At the point where Client #1 completed half of her meal, the staff took the remaining plate of food to the kitchen and indicated that it was to be kept for a later feeding. The staff then returned to the table and provided Client #1 with approximately 8oz of cranberry juice via her WonderFlo cup. As Client #1 drank her cranberry juice, the juice flowed down the side of her mouth and down onto her plastic bib with regular consistency. In addition, observation at her home on 11/18/2008 at approximately 6:05pm revealed, staff also failed to ensure a consistent implementation of providing sips of beverage between the servings of her pureed solids as recommended on her mealtime feeding protocol. Record review on 11/19/2008 at 3:05pm revealed Client #1 's Mealtime Feeding Protocol dated 9/13/2008 recommended that staff provide " thick liquids " to which the facility wrote in that the liquids should be of " nectar " consistency and that staff should " ..allow sips of beverage between pureed solids and after meal completion . Further record review revealed Client #1's Nutritional Assessment dated 9/13/2008 identified this client as having "chewing and swalling deficits". In addition, this client's Speech Assessment dated 10/13/2008 recommended that staff "continue to monitor oral motor and feeding skills for any signs/symptoms of aspiration".	W 474	W474 This Standard will be met as evidenced by: Cross reference W120, W189. The Home management and nurse have provided additional training to day program staff and home staff in regards to mealtime feeding equipment and protocol. In addition, additional nozzle feeders were provided to day program to ensure that client #1 has adequate equipment usage during mealtime. QMRP, Facility Coordinator and nurse will continue on-going monitoring of feeding during mealtime. DK	11/25/08

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W 474	Continued From page 10 Interview with HM and QMRP on 11/19/2008 at 3:24pm revealed Client #1 should have been provided sips of beverage between her solids and that her liquids should have been of " nectar " consistency. The facility failed to ensure that staff effectively employed Client #1 ' s meal time feeding protocol as required by this section.	W 474		
W 476	483.480(b)(3) MEAL SERVICES Food served to clients individually and uneaten must be discarded. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that uneaten food was discarded for one of three sampled clients. [Clients #1] The finding includes: Observation on 11/19/2008 at 11:42am at Client #1 ' s day program during lunch revealed her attending staff took the remaining food that was left in her plate and indicated she was going to store it for Client #1 to eat later because she liked to finish her meal an hour later. Record review on 11/19/2008 at 3:05pm revealed Client #1 ' s meal time feeding protocol recommended: " Two divided plates ... divide the meal onto both plates and keep one properly stored until she finishes the first. If she cannot tolerate the second plate, wait one hour and offer it again. " Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) and House Manager (HM) on 11/19/2008 at 3:06pm revealed they didn ' t consider Client #1 having one plate of	W 476	**W476** **This Standard will be met as evidenced by:** Cross reference W120,W 21 and W189 OK	12/4/08

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W 476	Continued From page 11 food at the day program during lunch as being a problem. In addition, both the OMRP and the HM indicated they were also not sure why the recommendation was made for Client #1 to have her meal split between two plates as opposed to the single plate serving option. The facility failed to ensure the integrity of the food as recommended in the meal time feeding protocol and as such failed to ensure the requirements of this section.	W 476		

Health Regulation Administration

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R 000	INITIAL COMMENTS This licensure survey was conducted from November 18, 2008 through November 20, 2008. The survey was initiated using the fundamental survey process. Six female residents with varying degrees of disabilities reside in this facility. Three of the six residents were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	R 000		

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STATE FORM WI9V11 If continuation sheet 1 of 1

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 2620 24TH STREET, NE WASHINGTON, DC 20018		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS This licensure survey was conducted from November 18, 2008 through November 20, 2008. The survey was initiated using the fundamental survey process. Six female residents with varying degrees of disabilities reside in this facility. Three of the six residents were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	I 000		
I 090	3504.1 HOUSEKEEPING 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: The facility failed to ensure the integrity of the physical environment as required by this section and as evidenced below. The finding includes: During the environmental inspection on 11/18/2008 at 4:25pm the following deficiencies were identified: 1. There were dark discolorations on the wall adjacent to the floor near the new washing machine which appeared to be mold. In addition, the repairs that were made to the wall was	I 090	**3504.1:** **This status will be met as evidenced by:** The Maintenance team has cleaned and painted over the dark discoloration on the wall and the repairs are now completed, also the hole on the wall of the back bathroom has been completed. Home management will ensure periodic monitoring of home and follow up with maintenance personnel for repairs of and work that needed to be done in the home.	12/4/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM W19V11

If continuation sheet 1 of 5

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I 090	Continued From page 1 unfinished. 2. An approximately 5 - 6 inch hole was observed in the wall behind the door of Bathroom #2 which is located on the south side of the building.	I 090		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that staff was effectively trained in implementing a resident's meal time feeding protocol for one of three sampled residents. [Resident #1] The finding includes: [Cross Reference Federal Report Citation W474] Observation on 11/19/2008 at 11:42am revealed staff at Resident #1's day program failed to serve liquids at the proper consistency, failed to ensure proper dispensing of liquids betweens servings of pureed solids, and failed to ensure the proper storage of food during meals. Staff interview on 11/19/2008 at approximately 11:55am at Resident #1's day program revealed the attending staff felt confident that she had served lunch correctly and in the manner of which she had received training.	I 229	**3510.1(f):** **This status will be met as evidenced by:** Cross reference W120,W 21 and W189	**11/25/08**

Health Regulation Administration

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	HFD03-0051		11/20/2008
NAME OF PROVIDER OR SUPPLIER: INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE: 2820 24TH STREET, NE WASHINGTON, DC 20018		

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I 229	Continued From page 2	I 229		
	Record review on 11/19/2008 at 3:05pm revealed Resident #1 ' s Mealtime Feeding Protocol dated 9/13/2008 recommended that staff provide " thick liquids " to which the facility wrote in that the liquids should be of " nectar " consistency and that staff should " ...allow sips of beverage between pureed solids and after meal completion ". Further record review revealed Resident #1's Nutritional Assessment dated 9/13/2008 identified this resident as having "chewing and swallowing deficits". In addition, this resident's Speech Assessment dated 10/13/2008 recommended that staff "continue to monitor oral motor and feeding skills for any signs/symptoms of aspiration".			
	The facility failed to ensure that staff at the day program was effectively trained in implementing Resident #1 ' s meal time feeding protocol as required by this section.			
I 472	3522.3 MEDICATIONS	I 472		
	The physician who identifies the self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation.		3522.3: This status will be met as evidenced by:	12/18/08
	This Statute is not met as evidenced by: Based on observations, interview and the review of records, the facility failed to ensure the monitoring of each residents self medication administration program to make certain residents participated in the training program, for one of three residents in the sample. (Resident #3)		Cross reference W371	
	The finding includes:			
	Observations of the evening medication			

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I472	Continued From page 3	I472		

administration on November 18, 2008 at 7:11 PM revealed Resident #3 was administered Norvasc 5 mg, Metformin 500 mg, Omeparazole 20 mg, and Diclofenac sodium 75 mg by mouth by the Licensed Practical Nurse (LPN). The LPN was observed to punch the medications into the cup and prepare the water for Resident #3. The nurse was further observed to place the medication cup and water on a small table in Resident #3's bedroom. Resident #3 consumed the medications and water independently without spillage. Interview with the LPN after the medication pass at approximately 7:19 PM revealed that Resident #3 was not on a self medication program.

Review of Resident #3's self medication assessment dated October 1, 2008 on November 19, 2008 at approximately 2:50 PM revealed the following strengths:

- Discriminate primary colors
- Identify printed or typed name from group of three
- Responds correctly to simple direction
- Correctly indicate times (s) of day when medications are given
- Takes medication with one prompt

Further review of the assessment revealed that the resident was not approved for a self medication program. The reason indicated that the resident was already participating with medication administration.

Interview with the facility's designated LPN on November 19, 2008 at 3:29 PM revealed that Resident #3 could punch medications into the cup, retrieve her medications, and tell time of day when medications are given. At the time of the

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I 472	Continued From page 4 survey, there was no evidence that the resident was given the opportunity to participate in a self-medication program.	I 472		