STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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	W 000		

An unannounced annual Medicaid ICF/ID Health Care Certification survey was conducted 3/1/16 through 3/3/16. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for the Mentally Retarded. The Life Safety Code survey report will follow.

RECEIVED
MAR 23 2016
VDH/OLC

The census in this six bed facility was five at the time of the survey. The survey sample consisted of three current Individual reviews (Individuals #1, #2 and # 3).

W 111 483.410(c)(1) CLIENT RECORDS

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure the clinical record was complete and accurate for two of three individuals in the survey sample, Individuals # 1 and # 3.

1. Facility staff failed to document a medication administration error on Individual # 1's medication administration record (MAR).

2. Facility staff failed to ensure Individual # 3's ISP (Individual Service Plan) included the "Aspiration Protocol" which documented Individual # 3's adaptive equipment.

W 111		
W111-483.410(c)(1)- Individual #1. 1. Medication error for individual #1 will be documented according to organization policy and procedure. =Staff that made the med error will receive a documented supervision and counseling from the supervising Registered Nurse focusing on the imperativeness of accurate measurements/ documentation of medications for individual #1 and all other individuals. 2. During next staff meeting, all staff assigned to the program will receive a medication refresher training on individual #1's/other individuals' medications and how to detect and document errors in a timely manner. =During staff meeting, all staff will take turns to measure individual #1's and similar medications for all other individuals' to demonstrate their understanding of prescribed quantities and what to do if there is an error.		4/10/16 and ongoing as needed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Clinical Director	3/21/16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 1 The findings include: 1. Individual # 1 was a 21 year old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism* (a developmental disorder that appears in the first 3 years of life. ASD {autism spectrum disorder} affects the brain's normal development of social and communication skills.), seizure disorder, scoliosis^ (a sideways curve of your backbone, or spine.) and post-traumatic stress disorder*^ (Post-traumatic stress disorder (PTSD) is a real illness. You can get PTSD after living through or seeing a traumatic event). On 3/2/16 at 6:30 a.m., medication administration observation was conducted. At 6:40 a.m., LPN (licensed practical nurse) # 1 prepared the following medication: polyethylene glycol. ** At 6:40 a.m., LPN # 1 was observed to prepare the medication inside the medication room. LPN # 1 removed the bottle of polyethylene glycol from the medication cabinet and placed it on the medication preparation shelf. LPN # 1 opened the bottle, removed the purple cap, poured some of the polyethylene glycol powder into the purple cap then poured the medication from the purple cap into a clear plastic graduated medicine cup. LPN # 1 repeated the process until the medicine cup was full. LPN # 1 was then asked to read how much polyethylene glycol powder was in the medicine cup. LPN # 1 stated, "Two tablespoons." LPN # 1 then poured the polyethylene glycol powder from the medicine cup into Individual # 1's cup of water, mixed it and Individual # 1 drank all of it in the presence of LPN # 1 and this surveyor.	W 111	=Efforts will be made to see if a pre-packed (17gr sachets) of individual #1 and all similar medications for can be ordered to avoid having to measure the medications each time it is being dispensed. This will ensure that measurements are always accurate. 3. Registered Nurse will conduct weekly audits of medications/documentation to ensure that all potential errors were captured and documented according to policy. 4. Clinical Director will review all medication error documentation to ensure that solid/ sustainable intervention measures have been put in place to forestall similar challenges in the future. Any suggestions for proficiency will be discussed with the Program and RN to discuss and implement with staff. =The department of Mission Effectiveness will conduct periodic medication observations, review of clinical documentation as needed or upon written request by the Clinical Director. Any deficiencies will be addressed with staff through additional training or other administrative action as needed.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 2 The POS (physician order sheet) dated 3/1/16 through 3/31/16 for Individual # 1 documented, "Polyeth Glyc (polyethylene glycol). Give 17 GMS (grams) in 8oz (eight ounces) of fluid twice daily for constipation." Review of the bottle of polyethylene glycol for Individual # 1 revealed directions on the back of the bottle. The directions documented, "1. NOTE: This product is supplied with a dosing cap marked to contain 17 grams of powder when filled to the indicated line. 2. Daily dose is 17 grams per day or as directed by physician. 3. Pour 17 grams (about 1 [one] heaping tablespoon full of powder into the dosing cup. 4. Stir the powder in a cup (4-8 oz. [ounces]) of water, juice, soda, coffee or tea until completely dissolved." On 3/2/16 at 7:40 a.m. an interview was conducted with LPN # 1 regarding the preparation of the polyethylene glycol for Individual #1. LPN # 1 stated he didn't use the cap from the polyethylene glycol bottle. LPN # 1 stated, "I just pour it into the cap to pour it into the medicine cup until I fill the medicine cup." LPN # 1 was asked to look at the cap from the polyethylene glycol and was asked if he knew that the cap on the polyethylene glycol was a dosing cup. After looking at the cap LPN # 1 stated, "I see something gram but can't tell." LPN # 1 was then asked to fill a medicine cup with polyethylene glycol powder as he did when he measured it for Individual # 1. After filling the medicine cup LPN # 1 was then asked to pour the polyethylene glycol powder back into the dosing cap from the polyethylene glycol bottle until it reached the 17 gram indicator line. Observation of the medicine cup revealed some polyethylene glycol powder	W 111	W111-483.410(c)(1)-For individual # 3 1. A meeting will be held with day program representatives to discuss the deficiency and together map out strategies on how to communicate better and share/keep information on individual #3 and all other individuals from the same residence that attend the day program. = An in-service training will be conducted by the Clinical Director for the QIDPs and all other staff that deputize to coordinate and monitor active treatment for individual #3 with emphasis on liaising communication/ operations with day program and providing documentation/ oversight to ensure that individual # 3's /other individuals' supports outlined in their treatment plans have the aspiration and all other applicable protocols in place. 2=: QIDPs or designees will conduct impromptu and unannounced monthly/ quarterly day program visits and observations for individual #3 and all other individuals attending the same or other day service locations to ensure that supports are provided to individuals as contracted and that treatment plan are complete and up to date.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 3	W 111		

from the bottle left in the medicine cup. When asked to read the amount of polyethylene glycol powder left in the medicine cup, LPN # 1 stated, "About two teaspoons." When asked if he had given Individual # 1 more than 17 grams of polyethylene glycol LPN # 1 stated, "Yes." When asked if this was a medication error LPN # 1 stated, "Yes."

On 3/3/16 the MAR (medication administration record) dated 3/1/16 through 3/31/16 for Individual # 1 was reviewed. The MAR documented, "Polyeth Glyc. Give 17 GMS in 8oz of fluid twice daily for constipation." Further review of the MAR revealed nurse's initials on 3/2/16 at 7:00 a.m. and where not circled. Under the heading "Medication Notes" it failed to evidence any documentation.

On 3/3/16 at 9:15 an interview was conducted with ASM (administrative staff member) # 2, corporate registered nurse. When asked to describe the procedure for documenting a medication error on the MAR, ASM # 2 stated, "Circle the date and document the error on the back of the MAR at the time of the error." After reviewing Individual # 1's MAR, LPN # 1 was asked if the MAR documented the medication error regarding the polyethylene glycol administered to Individual # 1on 3/2/16 ASM # 2 stated, "No."

The facility's policy "Medication Errors" documented, "3. Document medication administration that deviates from physician's orders on front of MAR by placing a circle around initials in appropriate space. On back of MAR, document name of medication, dosage, time and

3. Program manager will review all monthly/quarterly day program observations/record review notes once every month and/or quarter and discuss areas of concern with core team members during some of the weekly program operations meetings.
4. Clinical Director will receive and review notes from day program visits to ensure that service delivery and contractual obligations are adequately met. Monthly or as needed supervision will occur with the program manager to discuss areas that may be deficient.
= The department of Mission Effectiveness with conduct periodic audits as needed or upon written request by the Clinical Director. The audits will focus on observing clinical operations and record reviews at the residential and vocational (day program) locations and deficiencies will be addressed accordingly and evidence of compliance provided to Mission Effectiveness with coordination by the Clinical Director.

4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 4	W 111		

route of administration, the name of physician notified and signature with title."

On 3/3/16 at 10:25 a.m. ASM (administrative staff member) # 1, program manager, was made aware of the findings.

No further information was provided prior to exit.

References:
* This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/001526.htm>

^ This information was obtained from the website: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024966/https://www.nlm.nih.gov/>

*^ This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html>

**Polyethylene glycol - used to treat occasional constipation. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/003462.htm>

2. Individual # 3 was a 56 year old male, who was admitted to (Name of Group Home) on 7/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual, seizure disorder* (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.), hypertension (high blood pressure), vitamin D deficiency, and anemia** (low iron).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 5	W 111		

Observation on 3/1/16 at 12:00 p.m. at (Name of Day Program) revealed Individual # 3 was having lunch. Individual # 3 was seated at a table and was provided with adaptive equipment. The adaptive equipment consisted of a raised/elevated platform for his plate, as high-sided plate, built up right bend spoon and a nosey cup. Further observation revealed Individual # 3 used the adaptive equipment with minimal assistance throughout the meal.

The "Nutritional Assessment" dated 4/7/15 for Individual # 3 at (Name of Day Program) documented, "Adaptive Equipment: 03/2015 POS (physician's order sheet) states use small nosey cup, may use elevated tray, use high-sided plate, use built up right bend spoon."

The POS (physician's order sheet) dated 3/1/16 through 3/31/16 for Individual # 3 at (Name of Day Program) documented, "Adaptive Equipment: may use small nosey cup, may use elevated tray, use built up right bend spoon, use high-sided plate."

Review of Individual # 3's ISP (individual service plan) and the most recent "Person-Center Review" (second quarter review) dated 12/31/15 at (Name of Day Program) failed to evidence Individual # 3's use of adaptive equipment and a copy of aspiration protocol for Individual # 3. Further review of Individual # 3's ISP documented, "Support Instructions." Under "#4 Self Help Skills" it documented, "DSP (day support professional) provides (Individual # 3) with assistance when needed to ensure his self-help skills are completed [Physical Supports]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 6	W 111		

Individual # 3's current ISP (individual service plan) dated 07/01/2015 through 06/30/2016 at (Name of Group Home) was reviewed. Under the heading "3. Shared Planning" it documented, "Outcome # 6. Safety: A. Aspiration Protocol. B. Seizure Protocol. C. Fall Protocol. D. High Blood Pressure Protocol. E. Skin Protocol." Review of the "Aspiration Protocol" documented, "Prevention: Use adaptive equipment as recommended (elevated tray, high sided plate, built up right bend spoon); Offer him a sip in a small nosey cup every few bits of food ..."

On 3/1/16 an interview was conducted at 12:40 p.m. with OSM (other staff member) # 2, program support specialist at (Name of Day Program). OSM # 2 was asked to review Individual # 3's ISP and the most recent "Person-Center Review" (second quarter review) dated 12/31/15 at (Name of Day Program). When asked if Individual # 3's adaptive equipment and aspiration protocol was included in Individual # 3's current ISP, OSM # 2 stated, "No. It should have been put on the ISP." When asked what the "Physical Supports" were for meals under the heading "Self-Help Skills", OSM # 2 stated, "A nosey cup, a raised tray, a built up right bend spoon, and high-sided plate." When asked if she reviews Individual # 3's ISP, OSM # 2 stated, "I review the ISP quarterly and yearly and check to make sure it is accurate." When asked if Individual # 3's ISP was accurate, OSM # 2 stated, "No because it doesn't have the adaptive equipment." OSM # 2 further stated, "I was not here at the time of the last review."

On 3/1/16 an interview was conducted at 3:40 p.m. with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 7	W 111		

Professional). When asked about the responsibility of the QIDP, OSM # 1 stated, "Monitor active treatment, ensure the ISP is complete and being followed, visit the day program and look at the book and make sure the plans are being followed and up to date." When asked about the aspiration protocol and adaptive equipment for Individual # 3, OSM # 1 stated, "The protocol with the adaptive equipment is part of (Individual # 3's) ISP and (Name of Day Program) should have a copy of it." When asked how often she goes to the day program site, OSM # 1 stated, "I go out to the program site once or twice a quarter to make sure active treatment is being done and the ISP is up to date." After being informed that (Name of Day Program) staff was unable to provide a copy of Individual # 3's aspiration protocol with the adaptive equipment for Individual # 3, OSM # 1 stated, "We had sent a copy to the day program after the annual review."

The facility policy "Individual Service Plan" documented,"4.1.3 Procedures. A. The ISP addresses at a minimum: 1. The consumer's needs and preferences; 3. Relevant psychological, behavioral, medical, rehabilitation, and nursing needs as a result of assessment(s); 6. Medical protocols, if applicable."

On 3/2/16 at 2:40 p.m. ASM (administrative staff member) # 1, program manager, was made aware of the findings.

No further information was provided prior to exit.

References:
* This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/seizures.ht

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 111	Continued From page 8 ml> ** This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/anemia.html>	W 111		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on day program record review and staff interview, it was determined that the facility staff failed to ensure that the QIDP (Qualified Intellectual Disabilities Professional) coordinated and monitored the individuals' active treatment programs for one of three individuals in the survey sample, Individual # 3. For Individual # 3 the QIDP failed to ensure Individual # 3's day program ISP (individual service plan) was complete and accurate. The findings include: Individual # 3 was a 56 year old male, who was admitted to (Name of Group Home) on 7/26/96. Diagnoses in the clinical record included but were not limited to: profound intellectual, seizure disorder* (symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain.), hypertension (high blood pressure), vitamin D deficiency, and anemia** (low iron). Observation on 3/1/16 at 12:00 p.m. at (Name of Day Program) revealed Individual # 3 was having lunch. Individual # 3 was seated at a table and	W 159	W111-483.410(c)(1)-For individual # 3 1. A meeting will be held with day program representatives to discuss the deficiency and together map out strategies on how to communicate better and share/keep information on individual #3 and all other individuals from the same residence that attend the day program. = An in-service training will be conducted by the Clinical Director for the QIDPs and all other staff that deputize to coordinate and monitor active treatment for individual #3 with emphasis on liaising communication/ operations with day program and providing documentation/ oversight to ensure that individual # 3's /other individuals' supports outlined in their treatment plans have the aspiration and all other applicable protocols in place.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 159	Continued From page 9 was provided with adaptive equipment. The adaptive equipment consisted of a raised/elevated platform for his plate, as high-sided plate, built up right bend spoon and a nosey cup. Further observation revealed Individual # 3 used the adaptive equipment with minimal assistance throughout the meal. The "Nutritional Assessment" dated 4/7/15 for Individual # 3 at (Name of Day Program) documented, "Adaptive Equipment: 03/2015 POS (physician's order sheet) states use small nosey cup, may use elevated tray, use high-sided plate, use built up right bend spoon." The POS (physician's order sheet) dated 3/1/16 through 3/31/16 for Individual # 3 at (Name of Day Program) documented, "Adaptive Equipment: may use small nosey cup, may use elevated tray, use built up right bend spoon, use high-sided plate." Review of Individual # 3's ISP (individual service plan) and the most recent "Person-Center Review" (second quarter review) dated 12/31/15 at (Name of Day Program) failed to evidence Individual # 3's use of adaptive equipment and a copy of aspiration protocol for Individual # 3. Further review of Individual # 3's ISP documented, "Support Instructions." Under "#4 Self Help Skills" it documented, "DSP (day support professional) provides (Individual # 3) with assistance when needed to ensure his self-help skills are completed [Physical Supports]." Individual # 3's current ISP (individual service plan) dated 07/01/2015 through 06/30/2016 at	W 159	2=: QIDPs or designees will conduct impromptu and unannounced monthly/ quarterly day program visits and observations for individual #3 and all other individuals attending the same or other day service locations to ensure that supports are provided to individuals as contracted and that treatment plan are complete and up to date. 3. Program manager will review all monthly/ quarterly day program observations/record review notes once every month and/or quarter and discuss areas of concern with core team members during some of the weekly program operations meetings. 4. Clinical Director will receive and review notes from day program visits to ensure that service delivery and contractual obligations are adequately met. Monthly or as needed supervision will occur with the program manager to discuss areas that may be deficient. = The department of Mission Effectiveness with conduct periodic audits as needed or upon written request by the Clinical Director. The audits will focus on observing clinical operations and record reviews at the residential and vocational (day program) locations and deficiencies will be addressed accordingly and evidence of compliance provided to Mission Effectiveness with coordination by the Clinical Director.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 159	Continued From page 10	W 159		

(Name of Group Home) was reviewed. Under the heading "3. Shared Planning" it documented, "Outcome # 6. Safety: A. Aspiration Protocol. B. Seizure Protocol. C. Fall Protocol. D. High Blood Pressure Protocol. E. Skin Protocol." Review of the "Aspiration Protocol" documented, "Prevention: Use adaptive equipment as recommended (elevated tray, high sided plate, built up right bend spoon); Offer him a sip in a small nosey cup every few bits of food ..."

On 3/1/16 an interview was conducted at 12:40 p.m. with OSM (other staff member) # 2, program support specialist at (Name of Day Program). OSM # 2 was asked to review Individual # 3's ISP and the most recent "Person-Center Review" (second quarter review) dated 12/31/15 at (Name of Day Program). When asked if Individual # 3's adaptive equipment and aspiration protocol was included in Individual # 3's current ISP, OSM # 2 stated, "No. It should have been put on the ISP." When asked what the "Physical Supports" were for meals under the heading "Self-Help Skills", OSM # 2 stated, "A nosey cup, a raised tray, a built up right bend spoon, and high-sided plate." When asked if she reviews Individual # 3's ISP, OSM # 2 stated, "I review the ISP quarterly and yearly and check to make sure it is accurate." When asked if Individual # 3's ISP was accurate, OSM # 2 stated, "No because it doesn't have the adaptive equipment." OSM # 2 further stated, "I was not here at the time of the last review."

On 3/1/16 an interview was conducted at 3:40 p.m. with OSM (other staff member) # 1, the QIDP (Qualified Intellectual Disabilities Professional). When asked about the responsibility of the QIDP, OSM # 1 stated, "Monitor active treatment, ensure the ISP is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 159	Continued From page 11	W 159		

complete and being followed, visit the day program and look at the book and make sure the plans are being followed and up to date." When asked about the aspiration protocol and adaptive equipment for Individual # 3, OSM # 1 stated, "The protocol with the adaptive equipment is part of (Individual # 3's) ISP and (Name of Day Program) should have a copy of it." When asked how often she goes to the day program site, OSM # 1 stated, "I go out to the program site once or twice a quarter to make sure active treatment is being done and the ISP is up to date." After being informed that (Name of Day Program) staff was unable to provide a copy of Individual # 3's aspiration protocol with the adaptive equipment for Individual # 3, OSM # 1 stated, "We had sent a copy to the day program after the annual review."

On 3/2/16 at 2:40 p.m. ASM (administrative staff member) # 1, program manager, ASM # 2, corporate nurse, and ASM # 3, clinical director were made aware of the findings.

No further information was provided prior to exit.

References:
* This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/seizures.html>
** This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/anemia.html>

W 369 483.460(k)(2) DRUG ADMINISTRATION — W 369

The system for drug administration must assure that all drugs, including those that are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 369	Continued From page 12 self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and staff interview, it was determined that a medication was not administered without error for one of three individuals in the survey sample, Individual # 1. For Individual # 1 the facility staff failed to administer polyethylene glycol** according to the physician's order. The findings include: Individual # 1 was a 21 year old female, who was admitted to (Name of Group Home) on 2/19/13. Diagnoses in the clinical record included but were not limited to: mild intellectual disability, autism* (a developmental disorder that appears in the first 3 years of life. ASD {autism spectrum disorder} affects the brain's normal development of social and communication skills.), seizure disorder, scoliosis^ (a sideways curve of your backbone, or spine.) and post-traumatic stress disorder*^ (Post-traumatic stress disorder (PTSD) is a real illness. You can get PTSD after living through or seeing a traumatic event). On 3/2/16 at 6:30 a.m., medication administration observation was conducted. At 6:40 a.m., LPN (licensed practical nurse) # 1 prepared the following medication: polyethylene glycol. ** At 6:40 a.m., LPN # 1 was observed to prepare the medication inside the medication room. LPN # 1 removed the bottle of polyethylene glycol from the medication cabinet and placed it on the	W 369	1. Medication error for individual #1 will be documented according to organization policy and procedure. =Staff that made the med error will receive a documented supervision and counseling from the supervising Registered Nurse focusing on the imperativeness of accurate measurements/documentation of medications for individual #1 and all other individuals. 2. During next staff meeting, all staff assigned to the program will receive a medication refresher training on individual #1's/other individuals' medications and how to detect and document errors in a timely manner. =During staff meeting, all staff will take turns to measure individual #1's and similar medications for all other individuals' to demonstrate their understanding of prescribed quantities and what to do if there is an error. =Efforts will be made to see if a pre-packed (17gr sachets) of individual #1 and all similar medications for can be ordered to avoid having to measure the medications each time it is being dispensed. This will ensure that measurements are always accurate.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 369	Continued From page 13 medication preparation shelf. LPN # 1 opened the bottle, removed the purple cap, poured some of the polyethylene glycol powder into the purple cap then poured the medication from the purple cap into a clear plastic graduated medicine cup. LPN # 1 repeated the process until the medicine cup was full. LPN # 1 was then asked to read how much polyethylene glycol powder was in the medicine cup. LPN # 1 stated, "Two tablespoons." LPN # 1 then poured the polyethylene glycol powder from the medicine cup into Individual # 1's cup of water, mixed it and Individual # 1 drank all of it in the presence of LPN # 1 and this surveyor. The POS (physician order sheet) dated 3/1/16 through 3/31/16 for Individual # 1 documented, "Polyeth Glyc (polyethylene glycol). Give 17 GMS (grams) in 8oz (eight ounces) of fluid twice daily for constipation." The MAR (medication administration record) dated 3/1/16 through 3/31/16 for Individual # 1 was reviewed. The MAR documented, "Polyeth Glyc. Give 17 GMS in 8oz of fluid twice daily for constipation." Review of the bottle of polyethylene glycol for Individual # 1 revealed directions on the back of the bottle. The directions documented, "1. NOTE: This product is supplied with a dosing cap marked to contain 17 grams of powder when filled to the indicated line. 2. Daily dose is 17 grams per day or as directed by physician. 3. Pour 17 grams (about 1 [one] heaping tablespoon full of powder into the dosing cup. 4. Stir the powder in a cup (4-8 oz. [ounces]) of water, juice, soda, coffee or tea until completely dissolved."	W 369	3. Registered Nurse will conduct weekly audits of medications/documentation to ensure that all potential errors were captured and documented according to policy. 4. Clinical Director will review all medication error documentation to ensure that solid/ sustainable intervention measures have been put in place to forestall similar challenges in the future. Any suggestions for proficiency will be discussed with the Program and RN to discuss and implement with staff. =The department of Mission Effectiveness will conduct periodic medication observations, review of clinical documentation as needed or upon written request by the Clinical Director. Any deficiencies will be addressed with staff through additional training or other administrative action as needed.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 369	Continued From page 14	W 369		

On 3/2/16 at 7:40 a.m. an interview was conducted with LPN # 1 regarding the preparation of the polyethylene glycol for Individual #1. LPN # 1 stated he didn't use the cap from the polyethylene glycol bottle. LPN # 1 stated, "I just pour it into the cap to pour it into the medicine cup until I fill the medicine cup." LPN # 1 was asked to look at the cap from the polyethylene glycol and was asked if he knew that the cap on the polyethylene glycol was a dosing cup. After looking at the cap LPN # 1 stated, "I see something gram but can't tell." LPN # 1 was then asked to fill a medicine cup with polyethylene glycol powder as he did when he measured it for Individual # 1. After filling the medicine cup LPN # 1 was then asked to pour the polyethylene glycol powder back into the dosing cap from the polyethylene glycol bottle until it reached the 17 gram indicator line. Observation of the medicine cup revealed some polyethylene glycol powder from the bottle left in the medicine cup. When asked to read the amount of polyethylene glycol powder left in the medicine cup, LPN # 1 stated, "About two teaspoons." When asked if he had given Individual # 1 more than 17 grams of polyethylene glycol LPN # 1 stated, "Yes." When asked if this was a medication error LPN # 1 stated, "Yes."

On 3/2/16 at 2:40 p.m. ASM (administrative staff member) # 1, program manager, ASM # 2, corporate nurse, and ASM # 3, clinical director were made aware of the findings.

No further information was provided prior to exit.

References:
* This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 369	Continued From page 15 <https://www.nlm.nih.gov/medlineplus/ency/article/001526.htm> ^ This information was obtained from the website: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024966/https://www.nlm.nih.gov/> *^ This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html> **Polyethylene glycol - used to treat occasional constipation. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/ency/article/003462.htm>	W 369		
W 390	483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, staff interviews and facility document review it was determined that the facility staff failed to ensure expired medications were not available for use at the (Name of Group Home). The findings include: On 3/2/16 at 8:00 a.m. an observation of the contents of a two door metal cabinet, located in the medication room of (Name of Group Home) was conducted in the presence of LPN (licensed practical nurse) # 1. Observation of the medications within the cabinet revealed the	W 390	1. During the next staff meeting, expired medications will be discussed and staff advised to be vigilant and trained on how to review medications for any potential ones that may be out of date. 2. The Licensed Practical Nurse (LPN) will check all medications monthly to ensure that expired medications are taken out of active medications. 3. The RN coordinator will design a system to track expiration of all medications especially those not routinely used (PRNs). The expiration dates will be marked on a calendar (manual/electronic) to anticipate/ facilitate the purging of expired medications without having to repeatedly go through them manually.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 390	Continued From page 16 following medications to be expired: · One Albuterol Sulfate* inhaler/8.5 g (grams). Expired 01/2016 - (used to treat difficult breathing). · One tube of Clindamycin Phosphate topical gel**/60 grams. Expired 02/2016 - (antibacterial cream). · One tube of Triamcinolone Acetonide cream***/80 grams - (used to treat a variety of skin conditions). On 3/2/16 at 8:30 a.m. an interview was conducted with LPN # 1. LPN #1 was asked to describe the procedure to ensure expired medication where not available for use. LPN # 1 stated, "Go through the medications at least once a month and pull out any expired medications and then they are destroyed." After reviewing the Albuterol Sulfate, Clindamycin Phosphate and the Triamcinolone Acetonide cream, LPN # 1 agreed that they were expired. The medications were immediately removed from the cabinet. (Name of Group Home) policy titled, "Disposal of Medication" documented: "A. Remove all medications (prescription, controlled, and over-the-counter) that are expired or discontinued from their individual medication storage container." On 3/2/16 at 2:40 p.m. ASM (administrative staff member) # 1, program manager, ASM # 2, corporate nurse, and ASM # 3, clinical director were made aware of the findings. No further information was provided prior to exit. *Albuterol Sulfate Taken from	W 390	=The Registered Nurse (RN) coordinator will work with the LPN monthly to review expired medications, dispose of them and document accordingly. 4. The program manager will discuss any potential medication issues with the Clinical Director during monthly or other supervision. =The department of Mission Effectiveness will conduct routine audits (to include checking for expired medications) as needed or upon written request from the Clinical Director. Any lapses will be used as additional training opportunities for staff to learn and refine current tracking systems in place for medication storage/management and dispensing.	4/10/16 and ongoing as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G027	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE JACKSON DRIVE GROUP HOME	10144 LAKE JACKSON DRIVE MANASSAS, VA 20111

(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 390	Continued From page 17	W 390		

https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682145.html

**Clindamycin Phosphate topical gel
Taken from
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=8e76c7c7-04fd-47c9-8db9-6f74ceffe144

***Triamcinolone Acetonide cream
Taken from
http://https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=92a1ded0-8e1a-4994-9c8a-89e84fc85c94