

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2015
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NAME OF PROVIDER OR SUPPLIER  OPPORTUNITY ENTERPRISES	STREET ADDRESS, CITY, STATE, ZIP CODE 501 ALBERT ST VALPARAISO, IN 46383
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W 000  Bldg. 00	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: January 20, 21, 22 and 23, 2015.</p> <p>Facility number: 004789 Provider number: 15G726 AIM number: 200827230</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/4/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, for 1 of 3 sampled clients (client #1), the governing body failed to exercise general policy and operating direction over the facility to ensure it developed and implemented a policy and procedure to give group home and facility staff guidance on checking in client</p>	W 104	Beginning on January 1st, 2015, the agency began utilizing a new pharmacy. In preparation for this, the pharmacy was provided physician order sheets Dec 12,2014 to begin assembly of all residential client monthly medication supplies. Pharmacy contacted nursing department on 12/29/14, advising they did not	02/16/2015

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

TITLE

(X6) DATE

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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	<p>medications when delivered by the pharmacy to prevent medication errors. The governing body failed to exercise general policy and procedure over the facility to ensure its policy and procedures were implemented in regard to preventing neglect.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Please refer to W149: The governing body failed for 1 of 3 sampled clients (client #1), to implement written policy and procedures by neglecting to provide client #1 her prescribed medication.</li> <li>2. Please refer to W331: The governing body failed for 3 of 3 sampled clients (clients #1, #2 and #3), to ensure client #1's prescribed medication was available at the group home, to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking clients #2 and #3's vitals as ordered by the physician and failed to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT).</li> </ol> <p>9-3-1(a)</p>		<p>receive are quested refill prescription from physician's office for client #1's medication after numerous attempts. Client assigned nurse and pharmacy medical assistant both left phone and fax messages to physician's office without success to contact doctor for prescription. Client#1 assigned nurse consulted with nursing director, group home management and QDDP. No communication possible on 1/01/2015 related to holiday so client #1 did not receive the medication. Home staff generated a GER after notifying nurse morning and afternoon med pass times in regards to missing med as per policy. Client #1 did not shown any adverse reactions to not receiving her medication. Physician office returned call late morning of 1/2/15. Matters were complicated further as agency nurse learned client #1's physician was out of office for holiday until following week. During phone conversation, nurse requested urgent need of prescription to be brought to on-call physician. On-call physician did sent the script to the pharmacy on 1/2/15 at end of work day, and neglected to sign prescription. Pharmacy attempted to reach on-call physician office, but learned office now closed. Pharmacy informed medical assistant that they received a prescription for client #1 which was not signed by a</p>		

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W 149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (client #1), the facility neglected to implement written policy and procedure by neglecting to provide client #1 her prescribed medication.  Findings include:	W 149	physician, and thus unusable. When they called physician office to explain problem, they learned office now closed. Client #1 nurse attempted to call on-call physician. Answering service unwilling to contact physician as they had been given strict orders not to give messages regarding medication requests. At the end of day on 1/5/15, a signed script for client #1 arrived at the pharmacy and medication was available to the client on 1/6/15. The agency did ensure that client's vitals were taken and documented as prescribed. The Medication Administration Records, verify, through staff initials, that vitals were taken every Saturday, for client #2 and client #3. All physician ordered medication changes are discussed, monthly, at IDT meetings.  On January 1st, 2015, the QDDP was notified that the pharmacy failed to deliver the medication for client #1. On January 2nd, a BDDS report was submitted, by QDDP, advising of the medication error. Attached is a copy of the BDDS report, incident #661472, which was submitted on January 2nd, 2015. Beginning on January 1st, 2015, the agency began	02/16/2015	

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	<p>A review of the facility's records was conducted at the facility's administrative office on 1/21/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/3/15...Date of Knowledge: 1/4/15...Submitted Date: 1/5/15 involving client #1 indicated: "I QDDP (Qualified Developmental Disabilities Professional name) was notified that [client #1] did not receive her Clonazepam (Bipolar) 1 mg (milligram) at 7 A.M. and 8 P.M. on 1/3/15 and her 7 A.M. and 8 P.M. on 1/4/15. When talking with nursing on 1/2/15 [QDDP name] learned that [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1]'s medication after numerous attempts. Our agency switched pharmacies on January 1, 2015 and with this switch there was a lot of confusion between the pharmacy and the doctors. I [QDDP name] thought [Physician name]'s office sent the script to the pharmacy on Friday. After speaking with GHAM [Group Home Assistant Manager name] on 1/4/15 she informed [QDDP name] that when speaking to [Pharmacy name] (new pharmacy) they stated that [Physician</p>		<p>utilizing a new pharmacy. In preparation for this, the pharmacy was provided physician order sheets Dec 12,2014 to begin assembly of all residential client monthly medication supplies. Pharmacy contacted nursing department on 12/29/14, advising they did not receive a requested refill prescription from physician's office for client #1's medication after numerous attempts. Client assigned nurse and pharmacy medical assistant both left phone and fax messages to physician's office without success to contact doctor for prescription. Client#1 assigned nurse consulted with nursing director, group home management and QDDP. No communication possible on 1/01/2015 related to holiday so client #1 did not receive the medication. Home staff generated a GER after notifying nurse morning and afternoon med pass times in regards to missing med as per policy. Client #1 did not shown any adverse reactions to not receiving her medication. Physician office returned call late morning of 1/2/15. Matters were complicated further as agency nurse learned client #1's physician was out of office for holiday until following week. During phone conversation, nurse requested urgent need of prescription to be brought to on-call physician. On-call physician did sent the script to the pharmacy on 1/2/15</p>				

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	<p>name]'s office never sent over the script and the pharmacy was unable to fill the script due to not having a script from [client #1]'s doctor. [Client #1] has not shown any adverse reactions to not receiving he (sic) medication." Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the group home "General Event Reports (GER) was conducted on 1/23/15 at 9:00 A.M.. Review of the documented GERs dated 1/1/15 to 1/6/15 indicated:</p> <p>-GER dated 1/1/15 involving client #1 indicated: "Individual Name: [Client #1]...Event Type: Other: Medication not delivered...Event Time: 8:00 P.M....Event Summary: After being contacted by another manager from another group home, I, [GHAM], was checking medications on 12/31/14 to make sure that all of our medications had been delivered and were correct. I discovered that one of the controlled substance medications was not present. I immediately contacted the nurses phone and received no answer. I then called [QDDP name], explained the situation and she stated that she would call [Group Home Director (GHD)] and return information to me. After two hours, I</p>		<p>at end of work day, and neglected to sign prescription. Pharmacy attempted to reach on-call physician office, but learned office now closed. Pharmacy informed medical assistant that they received a prescription for client #1 which was not signed by a physician, and thus unusable. When they called physician office to explain problem, they learned office now closed. Client #1 nurse attempted to call on-call physician. Answering service unwilling to contact physician as they had been given strict orders not to give messages regarding medication requests. At the end of day on 1/5/15, a signed script for client #1 arrived at the pharmacy and medication was available to the client on 1/6/15.</p>	

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	<p>was contacted by [Assistant Manager of another group home] and told that there was still no solution to the problem. On 1/1/15 when I arrived to [Group Home name] I had received an email from [Nurse name] that stated if there were any issues with medications to email her a list of them and she would get them to [Facility Staff name] and have them corrected. I emailed [Nurse name] and waited for a response. After waiting for a half hour, I contacted [QDDP name], again and she stated she was in the process of figuring everything out. She then contacted me and stated that there was no solution at the time. To document in the MARS (Medication Administration Record) the reason the medication was not administered and complete a GER....Person/Entity Notified: [QDDP name] by phone... [Nurse name] by phone...Review By: [GHAM] on 1/1/15...[Nurse name] on 1/2/15, Review Comment: Group Homes were instructed per an email that went out on 12/31/14 that phone for GH (Group Home) would not be on until 1/1/15. That is why it was not answered on 12/31/14. [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1] after numerous attempts. I contacted [Physician name]'s office this am 1/2/15, they stated had a new request</p>			

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	<p>from pharmacy this am and will take care of it....reviewed by [QDDP name] on 1/2/15."</p> <p>-GER dated 1/2/15 involving client #1 indicated: "Medication Error Type: med not available...Time of Initial error: 7:00 A.M. and 8:00 P.M....Cause of error: Medication not available...Clonazepam 1 mg is not available at this time...Corrective actions taken: Notified [QDDP name], [Nurse name] and [GHAM name], filled out report, and continued to observe for any issues....Review by: [Nurse name] on 1/2/15 at 11:39 A.M....[QDDP name] on 1/2/15 at 3:39 P.M.."</p> <p>-GER dated 1/3/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/4/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/5/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not</p>			

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	<p>available...QDDP and Nurse notified."</p> <p>-GER dated 1/6/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M....Medication not available...QDDP and Nurse notified."</p> <p>A review of client #1's MAR dated 1/1/15 through 1/31/15 was conducted on 1/23/15 at 9:30 A.M.. Review of the record indicated:</p> <p>"1/1/15 6:00 P.M.: Clonazepam 1 mg not in house. Nurse and QDDP contacted. GER report completed.</p> <p>1/2/15 7:00 A.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/2/15 8:00 P.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/3/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/3/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/4/15 7:00 A.M. Clonazepam 1 mg is</p>			

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	<p>not available. Nurse and QDDP contacted. GER completed.</p> <p>1/4/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/5/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/5/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/6/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>A review of the facility's "Universal Policies and Procedures-Adult Services-Abuse and Neglect" policy dated 4/14/10 was conducted on 1/21/15 at 4:30 P.M.. Review of the policy indicated: "Opportunity Enterprises, Inc. does not condone and will not tolerate physical, verbal or sexual abuse, neglect or exploitation of individuals served....Definition-Neglect: Includes the refusal or failure to provide appropriate care, food, medical care or supervision."</p> <p>An interview with the Nursing Director (ND) was conducted at the facility's</p>			

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	<p>administrative office on 1/23/15 at 10:52 A.M.. The ND indicated client #1 did not have her medication on 1/1/15, 1/2/15, 1/3/15, 1/4/15, 1/5/15 and 1/6/15 because the medication was not delivered to the group home on 12/31/14. The ND further indicated the facility should have ensured client #1's prescribed medication was available as ordered for administration.</p> <p>An interview with the group home nurse, Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The group home nurse indicated client #1 did not receive her prescribed medication as ordered. The nurse further indicated the facility should have ensured client #1's prescribed medication was available as ordered for administration.</p> <p>9-3-2(a)</p>			

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W 220  Bldg. 00	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, record review and interview, the facility failed for 1 of 3 sampled (client #1) to ensure a speech assessment/reassessment was completed for a client who required assistance with communication skills.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/20/15 from 5:00 P.M. until 7:15 P.M.. During the entire observation client #1 was non-verbal in communication in that the client was limited to some one word answers that could not be understood. There was no communication teaching or training for client #1 during this observation.</p> <p>A morning observation was conducted at the group home on 1/23/15 from 5:30 A.M. until 8:00 A.M.. During the entire observation client #1 was non-verbal in communication in that the client was limited to some one word answers that could not be understood. There was no communication teaching or training for client #1 during this observation.</p> <p>A review of client #1's record was</p>			W 220	<p>Client #1 has a current formal goal regarding communication training. On 2.13.15, group home staff were retrained, by QDDP, on this communication goal for client #1. To ensure future compliance, QDDP will monitor formal active treatment, monthly. QDDP will also generate reports, concerning this and all other formal goals, to the Interdisciplinary Team, on a monthly basis. Client #1 will be taken to her primary care physician, to obtain a referral for a speech evaluation. To ensure compliance, that all participants have a comprehensive functional assessment, as a part of their Individual Service Plan, record reviews will be conducted, by the QDDP, on a monthly basis, and by the Group Home Director, on a quarterly basis.</p>		02/13/2015

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W 249 Bldg. 00	<p>conducted on 1/23/15 at 1:00 P.M.. Review of client #1's Individual Support Plan (ISP) dated 11/25/14 and/or record indicated she required assistance with communication. The record indicated a most current "Speech Evaluation" dated 11/6/03. There was no further documentation to indicate client #1's speech had been evaluated.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The QIDP indicated there was no documentation to indicate client #1's speech and/or language skills had been assessed since 11/6/03.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 2 of 3 sampled clients</p>	W 249	On 02/13/2015 group home staff were retrained by QDDP on providing formal and informal	02/22/2015			

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	<p>and 1 additional client (clients #1, #3 and #4), the facility failed to implement the clients' Individual Support Plan (ISPs) objectives when formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>An evening observation was conducted on 1/20/15 from 5:00 P.M. until 7:15 P.M.. During the entire observation period, client #4 was non-verbal in communication in that the client did not speak. No communication training was provided and/or encouraged. Client #1 only used 1 word answers during the entire observation. No communication training was provided and/or encouraged.</p> <p>A morning observation was conducted at the group home on 1/23/15 from 5:30 A.M. until 8:00 A.M.. During the entire observation period, client #4 was non-verbal in communication in that the client did not speak. No communication training was provided and/or encouraged. Client #1 only used 1 word answers during the entire observation. No communication training was provided and/or encouraged. At 6:05 A.M., clients #1, #2 and #4 sat at the dining table with no activity as Direct Support Professional (DSP) #1 poured oatmeal packets into bowls, put them into the</p>		<p>active treatment. To ensure compliance, confirmation of formal active treatment will be monitored, daily, for the first two weeks, by the QDDP, or their designee. After two weeks, the QDDP will conduct an assessment to determine if monitoring is able to be reduced. If monitoring is able to be reduced, monitoring will occur monthly, during QDDP quality assurance checks.</p>		

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	<p>microwave and placed the bowls at each client's place setting. At 6:10 A.M., DSP #1 placed bread into the toaster, placed the toast on a plate, put butter and jelly on the toast with a butter knife, cut the toast in half and placed the plate in front of client #4. Clients #1, #3 and #4 ate their meal independently. Clients #1, #3 and #4 were not involved in meal preparation.</p> <p>A review of client #1's record was conducted on 1/23/15 at 1:00 P.M.. Review of client #1's Individual Support Plan (ISP) dated 11/25/14 indicated: "Will make a complete sentence in A.M. and P.M. with verbal prompts... Will empty veg in bowl."</p> <p>A review of client #3's record was conducted on 1/23/15 at 1:55 P.M.. Review of client #3's Individual Support Plan (ISP) dated 3/11/14 indicated "Will empty veg in bowl."</p> <p>A review of client #4's record was conducted on 1/23/15 at 2:15 P.M.. Review of client #4's ISP dated 3/11/14 indicated "Will sign words."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The QIDP indicated the facility</p>			

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W 331 Bldg. 00	<p>staff should implement clients' training objectives at all times of opportunity.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 3 of 3 sampled clients and 1 additional client (clients #1, #2, #3 and #4), the facility's nursing services failed to ensure client #1's prescribed medication was available at the group home. The facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking clients #2 and #3's vitals as ordered by the physician. The facility's nursing staff failed to ensure the pharmacist's recommendations were reported to the physician and Interdisciplinary Team (IDT).</p> <p>Findings include:</p>	W 331	<p>On January 1st, 2015, the QDDP was notified that the pharmacy failed to deliver the medication for client #1. On January 2nd, a BDDS report was submitted, by QDDP, advising of the medication error. Attached is a copy of the BDDS report, incident #661472, which was submitted on January 2nd, 2015. Beginning on January 1st, 2015, the agency began utilizing a new pharmacy. In preparation for this, the pharmacy was provided physician order sheets Dec 12, 2014 to begin assembly of all residential client monthly medication supplies. Pharmacy contacted nursing department on 12/29/14, advising they did not receive a requested refill prescription from physician's office for client #1's medication after numerous attempts. Client assigned nurse and pharmacy</p>	02/16/2015

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	<p>1. A review of the facility's records was conducted at the facility's administrative office on 1/21/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/3/15...Date of Knowledge: 1/4/15...Submitted Date: 1/5/15 involving client #1 indicated: "I QDDP (Qualified Developmental Disabilities Professional name) was notified that [client #1] did not receive her Clonazepam (Bipolar) 1 mg (milligram) at 7 A.M. and 8 P.M. on 1/3/15 and her 7 A.M. and 8 P.M. on 1/4/15. When talking with nursing on 1/2/15 [QDDP name] learned that [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1]'s medication after numerous attempts. Our agency switched pharmacies on January 1, 2015 and with this switch there was a lot of confusion between the pharmacy and the doctors. I [QDDP name] thought [Physician name]'s office sent the script to the pharmacy on Friday. After speaking with GHAM [Group Home Assistant Manager name] on 1/4/15 she informed [QDDP name] that when speaking to [Pharmacy name] (new pharmacy) they stated that [Physician</p>		<p>medical assistant both left phone and fax messages to physician's office without success to contact doctor for prescription. Client#1 assigned nurse consulted with nursing director, group home management and QDDP. No communication possible on 1/01/2015 related to holiday so client #1 did not receive the medication. Home staff generated a GER after notifying nurse morning and afternoon med pass times in regards to missing med as per policy. Client #1 did not shown any adverse reactions to not receiving her medication. Physician office returned call late morning of 1/2/15. Matters were complicated further as agency nurse learned client #1's physician was out of office for holiday until following week. During phone conversation, nurse requested urgent need of prescription to be brought to on-call physician. On-call physician did sent the script to the pharmacy on 1/2/15 at end of work day, and neglected to sign prescription. Pharmacy attempted to reach on-call physician office, but learned office now closed. Pharmacy informed medical assistant that they received a prescription for client #1 which was not signed by a physician, and thus unusable. When they called physician office to explain problem, they learned office now closed. Client #1 nurse attempted to call on-call</p>				

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	<p>name]'s office never sent over the script and the pharmacy was unable to fill the script due to not having a script from [client #1]'s doctor. [Client #1] has not shown any adverse reactions to not receiving he (sic) medication." Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the group home "General Event Reports (GER) was conducted on 1/23/15 at 9:00 A.M.. Review of the documented GERs dated 1/1/15 to 1/6/15 indicated:</p> <p>-GER dated 1/1/15 involving client #1 indicated: "Individual Name: [Client #1]...Event Type: Other: Medication not delivered...Event Time: 8:00 P.M....Event Summary: After being contacted by another manager from another group home, I, [GHAM], was checking medications on 12/31/14 to make sure that all of our medications had been delivered and were correct. I discovered that one of the controlled substance medications was not present. I immediately contacted the nurses phone and received no answer. I then called [QDDP name], explained the situation and she stated that she would call [Group Home Director (GHD)] and return information to me. After two hours, I</p>		<p>physician. Answering service unwilling to contact physician as they had been given strict orders not to give messages regarding medication requests. At the end of day on 1/5/15, a signed script for client #1 arrived at the pharmacy and medication was available to the client on 1/6/15. The agency did ensure that client's vitals were taken and documented as prescribed. The Medication Administration Records verify, through staff initials, that vitals were taken every Saturday, for client #2 and client #3. All physician ordered medication changes are discussed, monthly, at IDT meetings.</p>		

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	<p>was contacted by [Assistant Manager of another group home] and told that there was still no solution to the problem. On 1/1/15 when I arrived to [Group Home name] I had received an email from [Nurse name] that stated if there were any issues with medications to email her a list of them and she would get them to [Facility Staff name] and have them corrected. I emailed [Nurse name] and waited for a response. After waiting for a half hour, I contacted [QDDP name], again and she stated she was in the process of figuring everything out. She then contacted me and stated that there was no solution at the time. To document in the MARS (Medication Administration Record) the reason the medication was not administered and complete a GER....Person/Entity Notified: [QDDP name] by phone... [Nurse name] by phone...Review By: [GHAM] on 1/1/15...[Nurse name] on 1/2/15, Review Comment: Group Homes were instructed per an email that went out on 12/31/14 that phone for GH (Group Home) would not be on until 1/1/15. That is why it was not answered on 12/31/14. [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1] after numerous attempts. I contacted [Physician name]'s office this am 1/2/15, they stated had a new request</p>			

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	<p>from pharmacy this am and will take care of it....reviewed by [QDDP name] on 1/2/15."</p> <p>-GER dated 1/2/15 involving client #1 indicated: "Medication Error Type: med not available...Time of Initial error: 7:00 A.M. and 8:00 P.M....Cause of error: Medication not available...Clonazepam 1 mg is not available at this time...Corrective actions taken: Notified [QDDP name], [Nurse name] and [GHAM name], filled out report, and continued to observe for any issues....Review by: [Nurse name] on 1/2/15 at 11:39 A.M....[QDDP name] on 1/2/15 at 3:39 P.M.."</p> <p>-GER dated 1/3/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/4/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/5/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not</p>			

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	<p>available...QDDP and Nurse notified."</p> <p>-GER dated 1/6/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M....Medication not available...QDDP and Nurse notified."</p> <p>A review of client #1's MAR dated 1/1/15 through 1/31/15 was conducted on 1/23/15 at 9:30 A.M.. Review of the record indicated:</p> <p>"1/1/15 6:00 P.M.: Clonazepam 1 mg not in house. Nurse and QDDP contacted. GER report completed.</p> <p>1/2/15 7:00 A.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/2/15 8:00 P.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/3/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/3/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/4/15 7:00 A.M. Clonazepam 1 mg is</p>			

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	<p>not available. Nurse and QDDP contacted. GER completed.</p> <p>1/4/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/5/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/5/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/6/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>An interview with the Nursing Director (ND) was conducted at the facility's administrative office on 1/23/15 at 10:52 A.M.. The ND indicated client #1 did not have her medication on 1/1/15, 1/2/15, 1/3/15, 1/4/15, 1/5/15 and 1/6/15 because the medication was not delivered to the group home on 12/31/14. The ND further indicated the facility should have ensured client #1's prescribed medication was available as ordered for administration.</p> <p>An interview with the group home nurse, Group Home Director (GHD) and the</p>			

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	<p>Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The group home nurse indicated client #1 did not receive her prescribed medication as ordered. The nurse further indicated the facility should have ensured client #1's prescribed medication was available as ordered for administration.</p> <p>2. A review of clients #2 and #3's Medication Administration Records (MARs) dated 2/1/14 to 11/1/14 was conducted on 1/23/15 at 12:20 P.M.. Review of the clients' records indicated:</p> <p>-Client #2: "Take Vitals Once Weekly-Saturdays." Further review did not indicate client #2's vitals were taken on 2/1/14, 2/8/14, 2/15/14, 2/22/14, 3/1/14, 3/8/14, 3/15/14, 3/22/14, 3/29/14, 4/5/14, 4/12/14, 4/19/14, 4/26/14, 5/3/14, 5/10/14, 5/17/14, 5/24/14, 5/31/14, 9/6/14, 9/13/14, 9/20/14, 9/27/14.</p> <p>-Client #3: "Take Vitals Once Weekly-Saturdays." Further review did not indicate client #3's vitals were taken on 2/1/14, 2/8/14, 2/15/14, 2/22/14, 3/1/14, 3/8/14, 3/15/14, 3/22/14, 3/29/14, 4/5/14, 4/12/14, 4/19/14, 4/26/14, 5/3/14, 5/10/14, 5/17/14, 5/24/14, 5/31/14, 9/6/14, 9/13/14, 9/20/14, 9/27/14.</p>			

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	<p>An interview with the facility's nurse was conducted on 1/23/15 at 2:50 P.M.. The nurse indicated all staff are to document clients #2 and #3's vitals as indicated on their MARs. The nurse indicated there was no documentation available for review to indicate the facility's nursing services monitored clients #2 and #3's vitals.</p> <p>3. A review of the facility's pharmacy reviews was conducted on 1/23/15 at 11:50 A.M.. The consulting pharmacist indicated:</p> <p>Consultation Report for Recommendation Created 6/10/14:</p> <p>"[Client #1] has been taking clonazepam (bi polar) for the past 6 months without a dosage reduction. Recommendation: Suggest dosage reduction for clonazepam-currently on 1 mg (milligram) bid (twice daily). Suggest trying .5 mg bid." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"This patient is no longer seeing [Physician name]. Please evaluate the</p>			

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	<p>need/necessity of [client #3]'s PRN (as needed) medication regimen and adjust if appropriate (Tylenol, artificial tears, q-tussin (cough suppressant), tums, benadryl, rulox (digestive problems)."</p> <p>Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>"[Client #4] is currently prescribed several PRN medications from [Physician name] (Milk of Mag., q-tussin, antacid/antigas, tums, Benadryl, ibuprofen and Tylenol). Please re-evaluate need for these medications and adjust accordingly." Further review failed to indicate the facility's nursing staff reported the pharmacist's recommendations to the IDT and physician.</p> <p>An interview with the Registered Nurse (RN) was conducted on 1/23/15 at 2:50 P.M.. The RN indicated the facility assigned a person who was responsible for reviewing the pharmacist's recommendations and reporting the recommendations to the IDT. The RN indicated the pharmacist's recommendations were not reported to the prescribing physician or the IDT by the assigned person.</p>			

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W 362 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>Based on record review and interview, the facility failed for 6 of 6 clients living at the group home, (clients #1, #2, #3, #4, #5 and #6) to ensure the pharmacist reviewed clients' medications on a quarterly basis.</p> <p>Findings include:</p> <p>The pharmacist's medication review record was reviewed on 1/23/15 at 11:50 A.M.. Review of the pharmacist's medication review record indicated no medication reviews for the first, third and fourth quarters of 2014 for clients #1, #2, #3, #4, #5 and #6.</p> <p>A review of client #1's record was conducted on 1/23/15 at 1:00 P.M.. The</p>	W 362	All physician ordered medication changes are discussed, monthly, at IDT meetings. The nursing director will ensure all client medications are reviewed quarterly, by pharmacist.	02/16/2015			

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	<p>record indicated client #1 was prescribed medications.</p> <p>A review of client #2's record was conducted on 1/23/15 at 1:30 P.M.. The record indicated client #2 was prescribed medications.</p> <p>A review of client #3's record was conducted on 1/23/15 at 2:00 P.M.. The record indicated client #3 was prescribed medications.</p> <p>A review of client #4's record was conducted on 1/23/15 at 2:15 P.M.. The record indicated client #4 was prescribed medications.</p> <p>A review of client #5's record was conducted on 1/23/15 at 2:30 P.M.. The record indicated client #5 was prescribed medications.</p> <p>A review of client #6's record was conducted on 1/23/15 at 2:40 P.M.. The record indicated client #6 was prescribed medications.</p> <p>An interview with the Registered Nurse (RN) was conducted at the facility's administrative office on 1/23/15 at 2:50 P.M.. When asked how often medications are to be reviewed by the pharmacist, the RN stated "They should</p>			

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W 368 Bldg. 00	<p>be reviewed quarterly." The RN further indicated there was no written documentation available for review to indicate medications were reviewed by the pharmacist.</p> <p>9-3-6(a)</p> <p>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. Based on record review and interview, the facility failed to assure drugs administered to 1 of 3 sampled clients (client #1) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/21/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/3/15...Date of Knowledge: 1/4/15...Submitted Date: 1/5/15 involving client #1 indicated: "I QDDP (Qualified Developmental Disabilities Professional name) was</p>	W 368	<p>On January 1st, 2015, the QDDP was notified that the pharmacy failed to deliver the medication for client #1. On January 2nd, a BDDS report was submitted, by QDDP, advising of the medication error. Attached is a copy of the BDDS report, incident #661472, which was submitted on January 2nd, 2015. Beginning on January 1st, 2015, the agency began utilizing a new pharmacy. In preparation for this, the pharmacy was provided physician order sheets Dec 12, 2014 to begin assembly of all residential client monthly medication supplies. Pharmacy contacted nursing department on 12/29/14, advising they did not receive a requested refill prescription from physician's office for client #1's medication after numerous attempts. Client assigned nurse and pharmacy medical assistant both left phone and fax messages to physician's office without success to contact</p>	02/16/2015

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	<p>notified that [client #1] did not receive her Clonazepam (Bipolar) 1 mg (milligram) at 7 A.M. and 8 P.M. on 1/3/15 and her 7 A.M. and 8 P.M. on 1/4/15. When talking with nursing on 1/2/15 [QDDP name] learned that [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1]'s medication after numerous attempts. Our agency switched pharmacies on January 1, 2015 and with this switch there was a lot of confusion between the pharmacy and the doctors. I [QDDP name] thought [Physician name]'s office sent the script to the pharmacy on Friday. After speaking with GHAM [Group Home Assistant Manager name] on 1/4/15 she informed [QDDP name] that when speaking to [Pharmacy name] (new pharmacy) they stated that [Physician name]'s office never sent over the script and the pharmacy was unable to fill the script due to not having a script from [client #1]'s doctor. [Client #1] has not shown any adverse reactions to not receiving he (sic) medication." Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the group home "General Event Reports (GER) was conducted on 1/23/15 at 9:00 A.M.. Review of the</p>		<p>doctor for prescription. Client#1 assigned nurse consulted with nursing director, group home management and QDDP. No communication possible on 1/01/2015 related to holiday so client #1 did not receive the medication. Home staff generated a GER after notifying nurse morning and afternoon med pass times in regards to missing med as per policy. Client #1 did not shown any adverse reactions to not receiving her medication. Physician office returned call late morning of 1/2/15. Matters were complicated further as agency nurse learned client #1's physician was out of office for holiday until following week. During phone conversation, nurse requested urgent need of prescription to be brought to on-call physician. On-call physician did sent the script to the pharmacy on 1/2/15 at end of work day, and neglected to sign prescription. Pharmacy attempted to reach on-call physician office, but learned office now closed. Pharmacy informed medical assistant that they received a prescription for client #1 which was not signed by a physician, and thus unusable. When they called physician office to explain problem, they learned office now closed. Client #1 nurse attempted to call on-call physician. Answering service unwilling to contact physician as they had been given strict orders</p>	

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	<p>documented GERs dated 1/1/15 to 1/6/15 indicated:</p> <p>-GER dated 1/1/15 involving client #1 indicated: "Individual Name: [Client #1]...Event Type: Other: Medication not delivered...Event Time: 8:00 P.M....Event Summary: After being contacted by another manager from another group home, I, [GHAM], was checking medications on 12/31/14 to make sure that all of our medications had been delivered and were correct. I discovered that one of the controlled substance medications was not present. I immediately contacted the nurses phone and received no answer. I then called [QDDP name], explained the situation and she stated that she would call [Group Home Director (GHD)] and return information to me. After two hours, I was contacted by [Assistant Manager of another group home] and told that there was still no solution to the problem. On 1/1/15 when I arrived to [Group Home name] I had received an email from [Nurse name] that stated if there were any issues with medications to email her a list of them and she would get them to [Facility Staff name] and have them corrected. I emailed [Nurse name] and waited for a response. After waiting for a half hour, I contacted [QDDP name], again and she stated she was in the</p>		not to give messages regarding medication requests. At the end of day on 1/5/15, a signed script for client #1 arrived at the pharmacy and medication was available to the client on 1/6/15.				

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	<p>process of figuring everything out. She then contacted me and stated that there was no solution at the time. To document in the MARS (Medication Administration Record) the reason the medication was not administered and complete a GER....Person/Entity Notified: [QDDP name] by phone... [Nurse name] by phone...Review By: [GHAM] on 1/1/15...[Nurse name] on 1/2/15, Review Comment: Group Homes were instructed per an email that went out on 12/31/14 that phone for GH (Group Home) would not be on until 1/1/15. That is why it was not answered on 12/31/14. [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1] after numerous attempts. I contacted [Physician name]'s office this am 1/2/15, they stated had a new request from pharmacy this am and will take care of it....reviewed by [QDDP name] on 1/2/15."</p> <p>-GER dated 1/2/15 involving client #1 indicated: "Medication Error Type: med not available...Time of Initial error: 7:00 A.M. and 8:00 P.M....Cause of error: Medication not available...Clonazepam 1 mg is not available at this time...Corrective actions taken: Notified [QDDP name], [Nurse name] and [GHAM name], filled out report, and</p>			

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	<p>continued to observe for any issues....Review by: [Nurse name] on 1/2/15 at 11:39 A.M....[QDDP name] on 1/2/15 at 3:39 P.M.."</p> <p>-GER dated 1/3/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/4/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/5/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/6/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M....Medication not available...QDDP and Nurse notified."</p> <p>A review of client #1's MAR dated 1/1/15 through 1/31/15 was conducted on 1/23/15 at 9:30 A.M.. Review of the record indicated:</p>			

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	"1/1/15 6:00 P.M.: Clonazepam 1 mg not in house. Nurse and QDDP contacted. GER report completed.  1/2/15 7:00 A.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/2/15 8:00 P.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/3/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/3/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/4/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/4/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/5/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.  1/5/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP			

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	<p>contacted. GER completed.</p> <p>1/6/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>An interview with the Nursing Director (ND) was conducted at the facility's administrative office on 1/23/15 at 10:52 A.M.. The ND indicated client #1 did not have her medication on 1/1/15, 1/2/15, 1/3/15, 1/4/15, 1/5/15 and 1/6/15 because the medication was not delivered to the group home on 12/31/14. The ND further indicated the facility should have ensured client #1's prescribed medication was available as ordered for administration.</p> <p>An interview with the group home nurse, Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The group home nurse indicated client #1 did not receive her prescribed medication as ordered. The nurse further indicated the facility should have ensured client #1's prescribed medication was available as ordered for administration.</p> <p>9-3-6(a)</p>			

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W 436  Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 3 sampled clients (clients #2 and #3) to provide footrests on client #3's wheelchair and to encourage the use of client #2's eyeglasses.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/20/15 from 5:00 P.M. until 7:15 P.M.. During the entire observation client #2 did not and was not prompted to wear eyeglasses. Client #3 was observed sitting in a standard wheelchair with no foot rests. Client #3 was observed with her legs and feet dangling.</p> <p>A morning observation was conducted at the group home on 1/23/15 from 5:30 A.M. until 8:00 A.M.. During the entire</p>	W 436	<p>On February 13th, 2015, QDDP trained staff on client #2's new IPP for wearing eye glasses. Client #2 can independently make an informed decision in regards to wearing her eye glasses, and she has demonstrated this ability in the past. Client #2's new formal IPP will ensure she has the ability to make that informed decision. The agency will provide footrests, for client #3, when she utilizes a wheelchair. No other clients were affected by this deficient practice. To ensure compliance, confirmation of formal active treatment will be monitored, daily, for the first two weeks, by the QDDP, or their designee. After two weeks, the QDDP will conduct an assessment to determine if monitoring is able to be reduced. If monitoring is able to be reduced, monitoring will occur monthly, during QDDP quality assurance checks.</p>	02/22/2015			

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	<p>observation client #2 did not and was not prompted to wear eyeglasses. Client #3 was observed sitting in a standard wheelchair with no foot rests. Client #3 was observed with her legs and feet dangling.</p> <p>A review of client #2's record was conducted on 1/23/15 at 1:30 P.M.. Review of client #2's Individual Support Plan (ISP) dated 11/6/14 indicated: "Vision Difficulties Mild Myopia (nearsightedness): Corrected glasses. Her 4/3/13 "Eye Exam" indicated: "Does need stronger glasses DX (Due to) Myopia."</p> <p>A review of client #3's record was conducted on 1/23/15 at 1:55 P.M.. Review of client #3's Individual Support Plan (ISP) dated 3/11/14 indicated she used a wheelchair for mobility at times.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The QIDP indicated the wheelchair client #3 was using should have foot rests to keep her feet from dangling. The QIDP indicated staff should encourage client #2 to wear her eyeglasses.</p> <p>9-3-7(a)</p>			

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W 484 Bldg. 00	<p>483.480(d)(3) DINING AREAS AND SERVICE</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the facility failed for 3 of 6 clients (clients #4, #5 and #6) living in the group home to provide condiments and table knives at the dining table.</p> <p>Findings include:</p> <p>An observation was conducted at the group on 1/23/15 from 5:30 A.M. until 8:00 A.M.. At 6:10 A.M., Direct Support Professional (DSP) #1 placed bread into the toaster, placed the toast on a plate, put butter and jelly on the toast with a butter knife, cut the toast in half and placed the plate in front of client #4. At 6:25 A.M., clients #4, #5 and #6 were observed eating their meal which consisted of oatmeal and toast. The table was</p>	W 484	<p>On 02/13/15 QDDP will retrain staff on active treatment which includes involving the clients in meal prep and serving themselves, according to their abilities. During the survey, and in the home's daily routine, butter and jelly are kept out, next to the toaster, on the kitchen counter, to be utilized after toast is made. To ensure compliance, confirmation of formal active treatment will be monitored, daily, for the first two weeks, by the QDDP, or their designee. After two weeks, the QDDP will conduct an assessment to determine if monitoring is able to be reduced. If monitoring is able to be reduced, monitoring will occur monthly, during QDDP quality assurance checks.</p>	02/22/2015

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W 488 Bldg. 00	<p>observed to have no milk, butter, sugar/sugar substitute, jelly, cinnamon or butter knives available for use. Direct Support Professional (DSP) #1 failed to offer these condiments and butter knives to clients #4, #5 and #6 for their food.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The QMRP indicated condiments and butter knives should be put on the table for the clients to use.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to assure 2 of 3 sampled clients and 1 additional client (clients #1, #3 and #4) were involved in meal preparation and served themselves.</p> <p>Findings include:  An observation was conducted at the group on 1/23/15 from 5:30 A.M. until</p>	W 488	On 02/13/15, QDDP retrained staff on active treatment which includes involving the clients in meal prep and serving themselves, according to their abilities. To ensure compliance, confirmation of formal active treatment will be monitored, daily, for the first two weeks, by the QDDP, or their designee. After two weeks, the QDDP will conduct an assessment to	02/22/2015

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	<p>8:00 A.M.. At 6:05 A.M., clients #1, #3 and #4 sat at the dining table with no activity as Direct Support Professional (DSP) #1 poured oatmeal packets into bowls, put them into the microwave and placed the bowls at each client's place setting. At 6:10 A.M., DSP #1 placed bread into the toaster, placed the toast on a plate, put butter and jelly on the toast with a butter knife, cut the toast in half and placed the plate in front of client #4. Clients #1, #3 and #4 ate their meal independently. Clients #1, #3 and #4 were not involved in meal preparation and did not serve themselves.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The QIDP indicated clients were capable of assisting in meal preparation with assistance and further indicated they should be assisting in preparation with assistance at meal time and serving themselves at all times.</p> <p>9-3-8(a)</p>		determine is monitoring is able to be reduced. If monitoring is able to be reduced, monitoring will occur monthly, during QDDP quality assurance checks.	

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W 999  Bldg. 00	<p>1. State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #1), to report a medication error to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/21/15 at 3:50 P.M.. Review of the facility's Bureau of Developmental</p>	W 999	<p>On January 1st, 2015, the QDDP was notified that the pharmacy failed to deliver the medication for client #1. On January 2nd, a BDDS report was submitted, by QDDP, advising of the medication error. Attached is a copy of the BDDS report, incident #661472, which was submitted on January 2nd,2015. Beginning on January 1st, 2015, the agency began utilizing a new pharmacy. In preparation for this, the pharmacy was provided physician order sheets Dec 12,2014 to begin assembly of all residential client monthly medication supplies. Pharmacy contacted nursing department on 12/29/14, advising they did not receive a requested refill prescription from physician's office for client #1's medication after numerous attempts. Client assigned nurse and pharmacy medical assistant both left phone and fax messages to physician's office without success to contact doctor for prescription. Client#1 assigned nurse consulted with nursing director, group home management and QDDP. No communication possible on 1/01/2015 related to holiday so client #1 did not receive the</p>	02/16/2015

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	<p>Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-BDDS report dated 1/3/15...Date of Knowledge: 1/4/15...Submitted Date: 1/5/15 involving client #1 indicated: "I QDDP (Qualified Developmental Disabilities Professional name) was notified that [client #1] did not receive her Clonazepam (Bipolar) 1 mg (milligram) at 7 A.M. and 8 P.M. on 1/3/15 and her 7 A.M. and 8 P.M. on 1/4/15. When talking with nursing on 1/2/15 [QDDP name] learned that [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1]'s medication after numerous attempts. Our agency switched pharmacies on January 1, 2015 and with this switch there was a lot of confusion between the pharmacy and the doctors. I [QDDP name] thought [Physician name]'s office sent the script to the pharmacy on Friday. After speaking with GHAM [Group Home Assistant Manager name] on 1/4/15 she informed [QDDP name] that when speaking to [Pharmacy name] (new pharmacy) they stated that [Physician name]'s office never sent over the script and the pharmacy was unable to fill the script due to not having a script from [client #1]'s doctor. [Client #1] has not</p>		<p>medication. Home staff generated a GER after notifying nurse morning and afternoon med pass times in regards to missing med as per policy. Client #1 did not shown any adverse reactions to not receiving her medication. Physician office returned call late morning of 1/2/15. Matters were complicated further as agency nurse learned client #1's physician was out of office for holiday until following week. During phone conversation, nurse requested urgent need of prescription to be brought to on-call physician. On-call physician did sent the script to the pharmacy on 1/2/15 at end of work day, and neglected to sign prescription. Pharmacy attempted to reach on-call physician office, but learned office now closed. Pharmacy informed medical assistant that they received a prescription for client #1 which was not signed by a physician, and thus unusable. When they called physician office to explain problem, they learned office now closed. Client #1 nurse attempted to call on-call physician. Answering service unwilling to contact physician as they had been given strict orders not to give messages regarding medication requests. At the end of day on 1/5/15, a signed script for client #1 arrived at the pharmacy and medication was available to the client on 1/6/15. On January 23rd, 2015, Human</p>				

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	<p>shown any adverse reactions to not receiving he (sic) medication." Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the group home "General Event Reports (GER) was conducted on 1/23/15 at 9:00 A.M.. Review of the documented GERs dated 1/1/15 to 1/6/15 indicated:</p> <p>-GER dated 1/1/15 involving client #1 indicated: "Individual Name: [Client #1]...Event Type: Other: Medication not delivered...Event Time: 8:00 P.M....Event Summary: After being contacted by another manager from another group home, I, [GHAM], was checking medications on 12/31/14 to make sure that all of our medications had been delivered and were correct. I discovered that one of the controlled substance medications was not present. I immediately contacted the nurses phone and received no answer. I then called [QDDP name], explained the situation and she stated that she would call [Group Home Director (GHD)] and return information to me. After two hours, I was contacted by [Assistant Manager of another group home] and told that there was still no solution to the problem. On 1/1/15 when I arrived to [Group Home</p>		Resources completed a third reference check for staff #13, bringing them into compliance. It is the policy of the Human Resources department, revised in 2014, that each applicant will have three completed references, before their admission into the orientation class (See Attached Policy). The agency will ensure this policy is upheld.		

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	<p>name] I had received an email from [Nurse name] that stated if there were any issues with medications to email her a list of them and she would get them to [Facility Staff name] and have them corrected. I emailed [Nurse name] and waited for a response. After waiting for a half hour, I contacted [QDDP name], again and she stated she was in the process of figuring everything out. She then contacted me and stated that there was no solution at the time. To document in the MARS (Medication Administration Record) the reason the medication was not administered and complete a GER...Person/Entity Notified: [QDDP name] by phone... [Nurse name] by phone...Review By: [GHAM] on 1/1/15...[Nurse name] on 1/2/15, Review Comment: Group Homes were instructed per an email that went out on 12/31/14 that phone for GH (Group Home) would not be on until 1/1/15. That is why it was not answered on 12/31/14. [Pharmacy name] was contacted and they did not receive a new script from [Physician name]'s office for [client #1] after numerous attempts. I contacted [Physician name]'s office this am 1/2/15, they stated had a new request from pharmacy this am and will take care of it....reviewed by [QDDP name] on 1/2/15."</p>			

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	<p>-GER dated 1/2/15 involving client #1 indicated: "Medication Error Type: med not available...Time of Initial error: 7:00 A.M. and 8:00 P.M....Cause of error: Medication not available...Clonazepam 1 mg is not available at this time...Corrective actions taken: Notified [QDDP name], [Nurse name] and [GHAM name], filled out report, and continued to observe for any issues....Review by: [Nurse name] on 1/2/15 at 11:39 A.M....[QDDP name] on 1/2/15 at 3:39 P.M.."</p> <p>-GER dated 1/3/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/4/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/5/15 involving [client #1] indicated: "Medication Error Type: Omission...Time of Initial Error: 7:00 A.M. and 8:00 P.M....Medication not available...QDDP and Nurse notified."</p> <p>-GER dated 1/6/15 involving [client #1] indicated: "Medication Error Type:</p>			

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	<p>Omission...Time of Initial Error: 7:00 A.M....Medication not available...QDDP and Nurse notified."</p> <p>A review of client #1's MAR dated 1/1/15 through 1/31/15 was conducted on 1/23/15 at 9:30 A.M.. Review of the record indicated:</p> <p>"1/1/15 6:00 P.M.: Clonazepam 1 mg not in house. Nurse and QDDP contacted. GER report completed.</p> <p>1/2/15 7:00 A.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/2/15 8:00 P.M.: Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/3/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/3/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/4/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/4/15 8:00 P.M. Clonazepam 1 mg is</p>			

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	<p>not available. Nurse and QDDP contacted. GER completed.</p> <p>1/5/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/5/15 8:00 P.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>1/6/15 7:00 A.M. Clonazepam 1 mg is not available. Nurse and QDDP contacted. GER completed.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 1/21/15 at 4:15 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...16. A medication error or medical treatment error as follows: ...c. missed medication...not given."</p> <p>An interview with the Nursing Director (ND) was conducted at the facility's administrative office on 1/23/15 at 10:52</p>			

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	<p>A.M.. The ND indicated client #1 did not have her medication on 1/1/15, 1/2/15, 1/3/15, 1/4/15, 1/5/15 and 1/6/15 because the medication was not delivered to the group home on 12/31/14.</p> <p>An interview with the Group Home Director (GHD) and the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/23/15 at 2:50 P.M.. The QIDP indicated the incident should have been reported immediately to the administrator and within 24 hours to BDDS. The QIDP further indicated the incident was not reported/reported timely to BDDS.</p> <p>9-3-1(b)</p> <p>2. State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any</p>			

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	<p>violent crime.</p> <p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 3 staff (staff #13) personnel files reviewed, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's administrative records were reviewed on 1/23/15 at 10:15 A.M.. Review of the personnel files for staff #13 indicated three references were not obtained. The personnel files indicated only two references were obtained for staff #13.</p> <p>An interview with the Human Resource Director (HRD) was conducted on 1/23/15 at 10:25 A.M.. The HRD</p>			

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	<p>indicated the facility's policy is that each employee should have three references, completed prior to employment with the facility. The HRD further indicated staff #13 did not have 3 completed references in their personnel record prior to employment.</p> <p>9-3-2(c)(3)</p>			