

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G576	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 503 N THIRD ST DECATUR, IN 46733		
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: September 26 and 27, 2013.</p> <p>Provider number: 15G576 Facility number: 001090 AIM number: 100245540</p> <p>Surveyor: Kathy Wanner, QIDP</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 10/3/13 by Ruth Shackelford, QIDP.</p>	W000000	Third Street Annual Recertification & Licensure Survey Plan of Correction Survey Event ID 2WL711 October 2013		

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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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>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 medications were administered according to the physician's orders for 2 of 3 sampled clients (clients #1 and #3) and for 3 of 3 additional clients (clients #4, #5 and #6).</p> <p>Findings include</p> <p>The facility records were reviewed on 9/26/13 at 10:40 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 9/26/12 through 9/26/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 3/5/13 for an incident on 3/1/13 at 12:00 P.M. indicated "[Client #3] did not receive his noon doses of Clonazepam (anti-convulsant) .5mg (milligram), Depakote (anti-convulsant/mood stabilizer) 500mg, and Chlorhexidine Rinse (oral rinse) 12% on 3/1/13 as a result of staff medication error...[Client #3] did not appear to experience any adverse effects as a result of these errors...."</p> <p>A BDDS report dated 4/19/13 for an incident on 4/17/13 at 8:15 P.M. indicated</p>	W000368	W368-Drug Administration The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. It is the intent of BCS that we meet the standard(s) of drug administration including the expectation that all drugs are administered in compliance with the physician's orders and are administered without error. BCS supports & safeguards in place have not proven to be 100% effective in the elimination of medication errors. Systemic changes to the medication administration process are in effect currently with Third starting use of multi-dose medication packs at cycle fill on 10/14/13. Use of multi-dose packs has been effective in reducing medication errors significantly in other group homes that started the multi-dose pack use in May & June 2013. In addition, one of the group homes will be implementing an eMAR system (oneMAR) effective 11/13, with Third designated for the same process once the system has been in place and any adjustments made per agency need(s). We are optimistic that the oneMAR system will eliminate medication errors. BCS was found to be deficient in this	10/27/2013	

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	<p>"[Client #6] received another consumer's medications, Depakote ER (extended release-anti-convulsant/mood stabilizer) 500mg and Benztropine (anti-parkinsonian) 1mg in error on 4/17/13. This error occurred due to direct care staff [name of staff], not following proper medication administration guidelines...No adverse effects were identified for [client #6] as a result of this error."</p> <p>A BDDS report dated 6/9/13 for an incident on 6/9/13 at 8:33 A.M. indicated "[Client #1] did not receive his dose of Digoxin (Cardiac) .125mg at his A.M. med. (medication) pass. The pill was found slightly dissolved on the floor beneath [client #1's] chair by the buddy checker..."</p> <p>A BDDS report dated 6/25/13 for an incident on 6/19/13 at 4:00 P.M. indicated "[Client #4] did not receive his PRN (as needed) prescription of Mucinex DM (expectorant) 600 mg on the evening of 6/19/13, both doses on 6/20, 6/21, 6/22, 6/23 and 6/24. His order reads to administer 2 (two) tabs (tablets) by mouth twice daily as needed for congestion. He (client #4) received his first dose and was seen by agency RN. Nursing ordered staff to follow the order for 5 (five) days. The order was not transcribed, and therefore</p>		<p>standard as evidenced by failure to administer medications for five of the six Third Street residents according to their physician's orders. Although Consumer # 6 died unexpectedly in June, this POC does address a serious medication error occurring when Consumer #6 received another individual's medications. Six significant errors for the five consumers occurred between 3/1/13 through 8/31/13, including 2 incidents of consumer(s) receiving a double dose of their prescribed medications, 2 incidents of missing medications and 1 incident of a consumer receiving another consumer's medication. This, of course, is unacceptable. In June and August of 2013, management and DCS received extensive training on medication administration, including competency testing of a challenging nature. In addition, there are multiple safeguards in place to prevent errors up to the point of actual administration and thereafter through the Buddy Check process. It is felt that the focus of corrective action for this citation will be on providing the Third Street staff with a Medication Administration Remediation Course provided by the RN's with competency testing geared toward problem areas/trends identified through the Incident Report (IR) process and recommendations from the</p>				

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	<p>not administered...[Client #4] did not have any adverse effects from the missed doses...."</p> <p>A BDDS report dated 7/24/13 for an incident on 7/23/13 at 9:00 P.M. indicated "On 7/22/13 [client #4] did not receive his bedtime dose of Olanzapine (anti-psychotic) 10mg and received a double dose of Clonazepam (anti-convulsant) .25 milligram in error... [Client #4] did not appear to experience any adverse effects as a result of this error...."</p> <p>A BDDS report dated 9/3/13 for an incident on 8/31/13 at 7:00 A.M. indicated "[Client #5] received a double dose of Phenobarb (anti-convulsant/sedative) 64.8mg at A.M. medication pass. [Client #5] did not suffer any adverse effects from the additional dose...."</p> <p>An interview was conducted with a facility RN on 9/26/13 at 2:59 P.M. When asked about the medication errors, the RN stated, "Staff weren't doing what they were supposed to do. We have recently become more meticulous on our training and especially on the observation check-off portion of the medication training. We always monitor a client after a medication error has occurred, take any</p>		<p>Medication Error Review Team (MERT).A.1 Corrective Action and Follow-Up specific to consumers # 1, 3, 4, 5 and 6 relating to Medication Errors: Consumer #3 (C3): 1. On 3/1/13 C3 did not receive his noon doses of Clonazepam 0.5 mg, Depakote 500 mg, and Chlorhexidine Oral Rinse 12%. This error occurred when C3 left Day Services to attend a scheduled outing for the majority of the day. The medication was not administered prior to leaving, and was not taken along. Upon his return, staff contacted agency RN's who advised holding the medications due to being too near the time of his next scheduled dose. C3 was monitored for adverse effects of missing these medications, and none were noted. In accordance with MERT recommendations, each staff member involved in this error (classroom staff and staff completing the outing) received a verbal warning for the error. Additionally, each staff member completed training regarding ensuring medications are accurately passed prior to outings, or taken along for administration at the appropriate time. The Employee Medication Error Record indicates neither staff involved has had any subsequent errors. Consumer #6 (C6): 1.On 4/17/13 C6 received another consumer's medications, including: Depakote ER 500 mg</p>				

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	<p>precautions we can, and notify their physician."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 9/27/13 at 12:42 P.M. The QIDP stated, "All of these errors were addressed by the MERT (medication error review team). I don't think we have had any re-occurrence of the same types of errors. Medical (nursing) developed several items to make sure medications are transcribed. We also have a log for when a medication comes in and it is transcribed. I think there was some confusion sometimes on who was responsible."</p> <p>An interview was conducted with the Program Director (PD) on 9/27/13 at 12:48 P.M. The PD stated, "Third shift also now checks all medications in addition to the buddy system which occurs right after each medication pass. It has made a significant difference since we recently started these additional precautions."</p> <p>9-3-6(a)</p>		<p>and Benztropine 1 mg. The medication was administered in error as a result of Direct Care Staff (DCS) not following proper medication administration guidelines as written and trained. C6 was monitored closely following this error, as directed by his physician. No adverse effects were noted during observation. In accordance with MERT recommendations, the staff person involved was immediately pulled from medication administration until training could be completed. She received a Written Warning due to the severity of the error. Additionally, the staff member was observed completing two medication passes (once by the House Manager and once by an agency RN). Both parties felt as though the staff member was competent, and she resumed passing medications. The Employee Medication Error Record indicates that following this error, the staff person involved did incur one further error on 6/21/13 of a similar nature. At that time, in accordance with MERT recommendations, the staff member was again suspended from passing medication as well as receiving a One-Day unpaid suspension. The staff member underwent thorough Competency Testing geared toward her personal record of error. Additionally, the staff member observed three peer medication</p>		

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			<p>passes and was observed passing medications twice by the House Manager before being cleared to resume medication administration. The Employee Medication Error Record indicates the staff member has not incurred any further errors since this date. Consumer #1 (C1): 1. On 6/9/13 C1 did not receive his A.M. dose of Digoxin .125 mg. This error occurred due to C1 apparently dropping the medication after administration. The pill was found later, partially dissolved beneath his chair and too much time had elapsed to re-administer. C1 was monitored for adverse effects of missing the medication, with no negative effects noted. The Medication Error Review Team (MERT) recommended retraining for all Third Street DCS over completing a thorough visual sweep of the medication area following each consumer's med administration, as outlined within the Proper Medication Administration Guidelines. This training was completed at the June house meeting. Consumer #4 (C4): 1. On 6/19/13 through 6/24/13, C4 did not receive his prescribed PRN doses of Mucinex DM 600 mg. C4 had been seen by an agency RN, who instructed staff to begin a 5-Day regimen of the PRN medication. The staff member who received the instruction failed to transcribe the order at the home, and the</p>		

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			<p>medication was therefore not started or given as needed. According to MERT recommendations, the staff member involved received training regarding starting PRN medication orders as instructed. Additionally, the process of beginning/transcribing PRN medications was trained on with all house staff at the July house meeting. 2. On 7/23/13, C4 did not receive his bedtime dose of Olanzapine 10 mg, instead receiving a double dosage of his bedtime Clonazepam 10 mg. Each of these medications are packaged in a small silver card which each pill is "popped" from, that is stored in a small plastic bag with the name of the medication affixed to the outside of the plastic bag. On this occasion, the staff member had mistakenly placed a silver card containing Clonazepam in the Olanzapine bag; the plastic bag on the outside stated the correct name during administration, though the medication within was incorrect. Still, according to MERT recommendations, the staff administering the medication was given a verbal warning for failure to compare the silver card with the MAR to assure accuracy. Additionally, all house staff received training regarding preventing this type of error at the August house meeting. An error of this type has not occurred</p>	

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			<p>since this training was completed. Consumer #5 (C5): 1. On 8/31/13, C5 received a double dosage of his A.M. Phenobarb 64.8 mg. The staff person administering medications "popped" two pills from the medication card in error due to failing to follow the Triple Check procedure as set forth within the Proper Medication Administration Guidelines. C5's physician was contacted and advised to monitor for adverse effects, none of which were noted. In accordance with MERT recommendations, the individual passing medications received a verbal warning. The staff member was recently hired and trained through Med Class, leading MERT to recommend further med administration training and support. The staff person received training with the house Medication Administration Mentor (MAM), as well as further observation from an agency RN. The staff member responsible for this error has not incurred any further errors since this training, according to the Employee Medication Error Record. A.2 Corrective Action for Staff working with Third Street Consumers: 1. All Third Street DCS will participate in a Medication Administration Remediation Course provided by the RN's & Medical Department staff. This will include competency testing, identifying and problem solving to assure</p>		

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			that all medications are given per physician's orders and without error. 2. Multi-dose packaging of medications for administration implemented 10/14/13 with DCS training prior to implementation Oct. 11th through 13th. 3. All Day Services staff administering medications will be provided with training addressing past problem areas in med administration in order to prevent future errors from occurring. Person's Responsible: Program Director (PD); RN's & Medical Department, Decatur Residential Management Team (RMT) and Administrative Assistant for Quality Assurance (AAQA). Target Completion Date: 10/27/13. B. Corrective Action for BCS Practices Agency Wide as it relates to Medication Administration: 1. All RMT members and supervisory staff working with residential consumers will be trained on identifying trends/patterns that prevent administering medications without error in their specific homes. Once trained and problem areas identified, the RMT will train their staff on item B.2 below. 2. All residential group home staff will receive training on prevention of errors that have been identified as problem areas for each specific group home. 3. All Supported Living (SL) DCS will receive training on prevention of errors that have been identified by the		

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			SL Management Teams specific to their consumers and settings. Person's Responsible: PD, AAQA and Management Teams. Target Completion Date: 10/27/13		