

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G545		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/14/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260			
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W0000	<p>This visit was for the investigation of complaint #IN00108415.</p> <p>Complaint #IN00108415: Substantiated, Federal/State deficiencies related to the allegation(s) are cited at W104, W149, W318, W331, and W368.</p> <p>Survey dates: June 11, 12, 13, and 14, 2012</p> <p>Facility Number: 001059 Provider Number: 15G545 AIM Number: 100245370</p> <p>Survey Team: Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/20/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed to exercise general policy and operating direction over the facility to prevent neglect of 1 of 4 sampled clients (client A). The governing body failed to exercise general policy and operating direction over the facility to ensure medications were administered correctly to client A and failed to ensure medication orders for client A were correctly transcribed onto the Medication Administration Record (MAR). The governing body failed to exercise general policy and operating direction over the facility to ensure the recommended treatment was completed for client A's fractured right little toe. The governing body failed to exercise general policy and operating direction over the facility to ensure all staff were re-trained in procedures for administering medications following discovery of reportable medication errors for client A. The governing body failed to exercise general policy and operating direction over the facility to ensure medical follow up on abnormal lab values for client A.</p> <p>Findings include:</p>	W0104	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Facility practices were reviewed during internal investigation of events from 5/14/12 – 5/21/12. The following measures were implemented to address the deficient practices that were noted during that internal investigation as well as the survey conducted. Client A discharged from the hospital to a skilled nursing facility per guardian request. Client A was discharged from St. Vincent New Hope services on May 28, 2012.</p> <p>Transcribing Medication</p> <p>The nurse consultant team met on 5/16/12 and developed a Procedure for Writing New or Changed Orders and Treatments. It specifies that each new or changed order will be written by a nurse on a medication administration record (MAR) which will then be double checked by an additional nurse or designee for accuracy. The sample MAR will be faxed or delivered to the site. The nurse consultant will then double check the site's MAR that the order was copied from the sample MAR accurately. Nursing team implemented procedure on 5/23/12.</p>	07/13/2012	

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	<p>Please see W149 for the governing body's failure to implement its policies and procedures to prevent medical neglect of client A.</p> <p>Please see W331 for the governing body failed to exercise operating direction of the agency's nursing services to prevent medical neglect of 1 of 4 sampled clients (client A).</p> <p>This federal tag relates to complaint #IN00108415.</p> <p>9-3-1(a)</p>		<p>Medication Administration Medication administration training will occur for all staff at the home. Medication administration observation by the Manager/QDDP (weekly) and the Nurse Consultant (2/mo) will occur and be documented on Medication Observation Sheets. Nursing team reviewed Medication Error procedure and revised to include training to occur by the nurse following a reportable medication error. Procedure also outlines progressive disciplinary action to coincide with retraining attempts.</p> <p>Availability of Medication Team Leader will conduct weekly medication counts to ensure that the appropriate amount of medication is available in the home for administration. Nurse Consultant will conduct a monthly medication count with the TL to ensure adequate supply is on hand and supply nursing oversight to medication count. QDDP will also conduct a monthly med count with the TL, on differing week from nurse consultant, to ensure the adequate supply remains on hand as well as provide additional oversight.</p> <p>Monitoring Labs Nursing Department continues to monitor lab values with physician following the Nursing Documentation Procedure. In the event that the</p>		

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			<p>physician does not respond, the nurse consultant will continue to request a response as indicated in the procedure q 48 hours.</p> <p>Appropriate Staffing QDDP and Team Leader have implemented a staffing plan which complies with support needs of the home and license allowances. Staff will be trained on the staffing pattern, attendance requirements and procedure for the home that outgoing staff may not leave until oncoming staff have arrived. In addition, Team Leader will address any attendance and tardy issues according to St. Vincent New Hope Policy and Procedure (attached). <i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All individuals in the home have the potential to be affected by these practices. All measures above will apply to all individuals in the home as a systematic corrective procedure change. In addition, Nurse consultant will review all seizure protocols for the other individuals in the home. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i> QDDP will monitor that weekly med counts are completed and provided adequate medication for all</p>		

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			<p>residents in home.</p> <p>Nurse Consultant will implement an Abnormal Lab tracking sheet for each individual to monitor lab values, communication with physician and results.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance continues to monitor medication errors monthly, sending a report to Director tracking trends and issues to address. Director will continue to review this report and address medication administration issues with the QDDP of the facility should they occur.</p> <p>Director will also conduct weekly meeting with facility team to monitor corrective measures are effective.</p> <p>IDT will meet monthly to address any ongoing nursing, behavior, social or other issues related to the individuals in the facility.</p> <p>Director will continue to monitor nursing and home charts through random monthly audits.</p>		

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W0149	<p>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, the facility neglected to implement its policies and procedures to prevent neglect of 1 of 4 sampled clients (client A). The facility neglected to ensure availability of prescribed medications and neglected to correctly transcribe medication orders for client A. The facility neglected to administer medications correctly to client A. The facility neglected to provide recommended treatment to client A following a fractured toe. The facility neglected to ensure staff were re-trained in procedures for administering medications following discovery of reportable medication errors for client A. The facility neglected to ensure medical follow up on abnormal lab values for client A.</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident reports from 03/08/2012 through 05/13/2012 were reviewed on 06/11/2012 at 1:50 p.m.</p> <p>An Indiana Division of Disability and</p>	W0149	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Facility practices were reviewed during internal investigation of events from 5/14/12 – 5/21/12. The following measures were implemented to address the deficient practices that were noted during that internal investigation as well as the survey conducted. Client A discharged from the hospital to a skilled nursing facility per guardian request. Client A was discharged from St. Vincent New Hope services on May 28, 2012.</p> <p>Transcribing Medication</p> <p>The nurse consultant team met on 5/16/12 and developed a Procedure for Writing New or Changed Orders and Treatments. It specifies that each new or changed order will be written by a nurse on a medication administration record (MAR) which will then be double checked by an additional nurse or designee for accuracy. The sample MAR will be faxed or delivered to the site. The nurse consultant will then double check the site's MAR that the order was copied from the sample MAR accurately. Nursing team implemented procedure on 5/23/12.</p>	07/13/2012			

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	<p>Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/13/2012 at 8:30 a.m., indicated client A did not receive Onfi (medication to treat seizures) 5 mg (milligrams) as prescribed at 8:30 a.m. and 8:30 p.m. on 05/12/2012.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/13/2012 at 8:30 a.m., indicated client A had a seizure lasting more than 15 minutes and required Emergency Medical Services to transport to the hospital for evaluation and treatment.</p> <p>Client A's record was reviewed on 06/13/2012 at 1:50 p.m. A laboratory report, dated 10/21/2011, indicated client A's Dilantin (seizure medication) level was 5.0 (normal = 10-20). The report indicated, "...recheck labs in 1 month..." The record did not indicate the lab was rechecked in a month.</p> <p>A laboratory report, dated 01/17/2012, indicated glucose 123 (normal = 65-99), creatinine (measures kidney function) 0.59 (normal = 0.8-1.3), ALT (liver enzyme) 136 (normal - 0-40), AST (another liver enzyme) 131 (normal = 0-37). The report indicated, "faxed to</p>		<p>Medication Administration Medication administration training will occur for all staff at the home. Medication administration observation by the Manager/QDDP (weekly) and the Nurse Consultant (2/mo) will occur and be documented on Medication Observation Sheets. Nursing team reviewed Medication Error procedure and revised to include training to occur by the nurse following a reportable medication error. Procedure also outlines progressive disciplinary action to coincide with retraining attempts.</p> <p>Availability of Medication Team Leader will conduct weekly medication counts to ensure that the appropriate amount of medication is available in the home for administration. Nurse Consultant will conduct a monthly medication count with the TL to ensure adequate supply is on hand and supply nursing oversight to medication count. QDDP will also conduct a monthly med count with the TL, on differing week from nurse consultant, to ensure the adequate supply remains on hand as well as provide additional oversight.</p> <p>Monitoring Labs Nursing Department continues to monitor lab values with physician following the Nursing Documentation Procedure. In the event that the</p>		

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	<p>[physician]...CBC (complete blood count) 1 x (time) now. Repeat labs in 3 weeks...." The record did not indicate the labs were obtained as requested.</p> <p>Physician's orders, dated 05/01/2012, indicated, "...PHENYTOIN (DILANTIN) 125 MG/5 ML LIQ (liquid) 100 MG, Frequency: THREE TIMES A DAY Instructions: 100 MG = 4 ML...RANITIDINE (ZANTAC used for treatment of esophageal reflux) TAB 150 MG, Frequency: TWICE A DAY...ASCORBIC ACID (antioxidant) TAB: 500 MG, Frequency: WITH BREAKFAST...VITAMIN E (supplement) CAPSULE 200 IU, Frequency: TWICE A DAY...."</p> <p>The MAR, dated 05/01/2012-05/31/2012, indicated, "...(all entries hand written) Onfi 5 mg give one (5 mg) every 12 hours through peg tube *control box*...Phenytoin (Dilantin) 125 mg/5 ml give 30 ml (100 mg) three times daily through peg tube...Ranitidine (Zantac) 150 mg give one twice daily through peg tube...Ascorbic Acid tab 500 mg give one tablet daily with breakfast through peg tube...Vitamin E capsule 200 IU give 400 IU 2 x daily through peg tube...." The MAR indicated incorrect doses of Phenytoin (750 mg instead of 100 mg) were administered at 8:30 a.m., 12:00</p>		<p>physician does not respond, the nurse consultant will continue to request a response as indicated in the procedure q 48 hours.</p> <p>Appropriate Staffing QDDP and Team Leader have implemented a staffing plan which complies with support needs of the home and license allowances. Staff will be trained on the staffing pattern, attendance requirements and procedure for the home that outgoing staff may not leave until oncoming staff have arrived. In addition, Team Leader will address any attendance and tardy issues according to St. Vincent New Hope Policy and Procedure (attached). <i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All individuals in the home have the potential to be affected by these practices. All measures above will apply to all individuals in the home as a systematic corrective procedure change. In addition, Nurse consultant will review all seizure protocols for the other individuals in the home. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i> QDDP will monitor that weekly med counts are completed and provided adequate medication for all</p>				

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	<p>p.m., and 9:00 p.m. on 05/02-05/10/2012 and at 8:30 a.m. on 05/11/2012. The MAR indicated Ranitidine was not given at 9:00 p.m. on 05/02/2012 and was not given on at 8:30 a.m. and 9:00 p.m. on 05/03/2012 and 05/04/2012. The MAR indicated the medication was not available for administration. The MAR indicated Onfi was not given on 5/12/2012 at 8:30 a.m. and 9:00 p.m. The record indicated the medication was not available for administration. The MAR indicated Ascorbic acid was not given because it was not available for administration on 05/02/2012-05/12/2012. The MAR indicated Vitamin E was not given at 9:00 p.m. on 05/01-05/03/2012 and was not given at 8:30 a.m. on 05/02-05/04/2012. The record indicated the medication was not available for administration.</p> <p>A radiology report, dated 05/09/2012, indicated client A had a broken right little toe. A hand written note, dated 05/09/2012, indicated, "[Client A] has...a cut on his Right little toe that needs cleaned and bandage changed every shift...." The record did not indicate the bandage was changed after it was applied on 05/09/2012.</p> <p>A hospital social service note dated 05/13/2012 indicated, "...pt (patient) not</p>		<p>residents in home.</p> <p>Nurse Consultant will implement an Abnormal Lab tracking sheet for each individual to monitor lab values, communication with physician and results.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance continues to monitor medication errors monthly, sending a report to Director tracking trends and issues to address. Director will continue to review this report and address medication administration issues with the QDDP of the facility should they occur.</p> <p>Director will also conduct weekly meeting with facility team to monitor corrective measures are effective.</p> <p>IDT will meet monthly to address any ongoing nursing, behavior, social or other issues related to the individuals in the facility.</p> <p>Director will continue to monitor nursing and home charts through random monthly audits.</p>				

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	<p>receiving proper dose of Dilantin...bandage on toe is frayed...Pt did not receive his Onfi today and the medication log shows the medication was unavailable in the house...."</p> <p>An Emergency Record, dated, 05/13/2012, indicated, "...pt w (with) intractable seizures- confusion over medications @ (at) group home. Will admit for further evaluation...."</p> <p>A hospital Discharge Summary, dated 5/31/2012, indicated client A was treated for intractable (hard to control) seizures. The record indicated client A was discharged to a skilled nursing facility.</p> <p>An "Associate Disciplinary Action Form," dated 05/15/2012, indicated, "...Reason for Action: On May 11, 2012... [Direct Support Professional (DSP) #11] passed the last pill from the control card and failed to notify the the nurse of TL (Team Leader)...The morning staff therefore did not have the medication to pass the next morning and 1st dose of medication was missed for this client (A)...[DSP #11] failed to then pass the 9:00 p.m. dose on 05/12/12, writing on the MARs that pill was not available, thus causing client (A) to miss 2nd dose of medication. Client (A) had adverse reaction due to the</p>				

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	<p>missed medications...."</p> <p>Staff training records were reviewed on 06/13/2012 at 4:30 p.m. The record did not indicate staff were re-trained in medication administration procedures including how to respond to discrepancies between the order written on the MAR and the medication labels.</p> <p>During an interview on 06/11/2012 at 5:45 p.m., Team Leader (TL) #1 indicated it was her responsibility to ensure medications were available in the home for administration. She indicated some medications were not re-ordered because the medication count record had not been updated to reflect all medications prescribed for client A.</p> <p>During an interview on 06/11/2012 at 6:40 p.m., DSP #7 indicated the facility did not have enough staff on some week ends. She stated, "Staff call in more on the week ends. Staff called in on Mother's Day (05/13/2012)."</p> <p>During a confidential interview on 06/12/2012 at 7:05 p.m., Confidential Interview (CI) stated "I am concerned about staffing, especially on the weekends." CI stated, "Registry staff are used on the week ends." CI indicated</p>						

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	<p>client A did not receive medications for seizure management correctly and indicated client A's bandage on his toe was not changed.</p> <p>During an interview on 06/13/2012 at 10:15 a.m., LPN #1 indicated labs were collected as requested by the physician. She indicated she did not receive or review copies of the labs and did not follow up with the physician in regard to the labs. The nurse stated, "[Client A's] mother took him to his appointments and got copies of the labs." She indicated the facility had not requested copies from the appointments. LPN #1 indicated medications had not been administered correctly to client A on 05/12/2012. She indicated the facility was unable to obtain the correct formula of Dilantin (liquid). She indicated the pharmacist was consulted in regard to equivalency of capsule form verses liquid form of Dilantin. LPN #1 indicated the physician had written an order to use the capsule form of Dilantin until the liquid form was available. A copy of the physician's order was requested but not provided. LPN #1 indicated client A did not receive 750 mg of Dilantin as documented on the MAR for May 1-12, 2012. She indicated the entry on the MAR was incorrectly transcribed, but given correctly. The nurse indicated DSPs did not consult her in</p>			

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	<p>regard to the discrepancies between the entry on the MAR and the label on client A's Dilantin. LPN #1 indicated staff were not re-trained in medication administration following medication errors for client A in May 2012. LPN #1 indicated the order for treatment to client A's right little toe had not been transcribed on the MAR and the treatment was not provided.</p> <p>During an interview on 06/14/2012 at 9:50 a.m., the Qualified Developmental Disabilities Professional (QDDP) indicated only one staff was present in the home from 7:05 a.m.-8:45 a.m. on 05/13/2012. She indicated a second staff was scheduled but called off her shift.</p> <p>A "Suspected Abuse" Policy, dated 09/2011 was reviewed on 06/11/2012 at 1:50 p.m. The policy indicated, "...Neglect is a practice that denies an individual any of the following without a physician's order: the repeated failure of a caregiver to provide supervision, training, appropriate care and the basic necessities of life such as denial of sleep, food, drink, shelter, clothing, and medical care or treatment...."</p> <p>A Medication Administration policy, dated 05/2012 was reviewed on 06/13/2012 at 7:05 p.m. The policy</p>						

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	<p>indicated, "...When passing prescribed medications, all such associates will follow the specific steps outlined in the Medication Administration Core A and B training course..."</p> <p>"Living in the Community Core A", Copyright 2004, was reviewed on 06/13/2012 at 7:30 p.m. The curriculum indicated, "...Make sure that the information on the medicine sheet corresponds exactly to the label on the individual's medication. If it does not, ask the staff nurse for further instructions and check your agency policy...THE "SIX RIGHTS" OF MEDICATION ADMINISTRATION: 1. Right medication...2. Right dose...3. Right individual...4. Right route...5. Right time...6. Right documentation..."</p> <p>This federal tag relates to complaint #IN00108415.</p> <p>9-3-2(a)</p>				

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (client A). The facility's health care services failed to ensure nursing services monitored and followed up on abnormal lab values for client A. The facility's health services failed to ensure seizure medications were administered correctly to client A which resulted in a seizure lasting more than 15 minutes and hospitalization. The facility's health services failed to provide recommended treatment to client A's right little toe following a fracture. The facility failed to ensure staff were re-trained in medication administration following reportable medication errors.</p> <p>Findings include:</p> <p>The facility's nursing services failed to monitor the health conditions of client A in regard to collecting laboratory tests when ordered and obtaining medical follow up for abnormal lab results. The facility's nursing services failed to ensure client A had all medications available for administration and failed to ensure the correct formula/dose of Dilantin was</p>	W0318	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Facility practices were reviewed during internal investigation of events from 5/14/12 – 5/21/12. The following measures were implemented to address the deficient practices that were noted during that internal investigation as well as the survey conducted. Client A discharged from the hospital to a skilled nursing facility per guardian request. Client A was discharged from St. Vincent New Hope services on May 28, 2012.</i></p> <p>Transcribing Medication The nurse consultant team met on 5/16/12 and developed a Procedure for Writing New or Changed Orders and Treatments. It specifies that each new or changed order will be written by a nurse on a medication administration record (MAR) which will then be double checked by an additional nurse or designee for accuracy. The sample MAR will be faxed or delivered to the site. The nurse consultant will then double check the site's MAR that the order was copied from the sample MAR accurately. Nursing team implemented procedure on 5/23/12. Medication</p>	07/13/2012			

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	<p>given to client A. The facility's nursing services failed to ensure seizure medications were administered resulting in client A's hospitalization due to a prolonged seizure. The facility's nursing services failed to ensure staff were re-trained in medication administration procedures following reportable medication errors. Please see W331.</p> <p>This federal tag relates to complaint #IN00108415.</p> <p>9-3-6(a)</p>		<p>Administration Medication administration training will occur for all staff at the home. Medication administration observation by the Manager/QDDP (weekly) and the Nurse Consultant (2/mo) will occur and be documented on Medication Observation Sheets. Nursing team reviewed Medication Error procedure and revised to include training to occur by the nurse following a reportable medication error. Procedure also outlines progressive disciplinary action to coincide with retraining attempts.</p> <p>Availability of Medication Team Leader will conduct weekly medication counts to ensure that the appropriate amount of medication is available in the home for administration. Nurse Consultant will conduct a monthly medication count with the TL to ensure adequate supply is on hand and supply nursing oversight to medication count. QDDP will also conduct a monthly med count with the TL, on differing week from nurse consultant, to ensure the adequate supply remains on hand as well as provide additional oversight. Monitoring Labs Nursing Department continues to monitor lab values with physician following the Nursing Documentation Procedure. In the event that the physician does not respond, the nurse consultant will continue to</p>		

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			request a response as indicated in the procedure q 48 hours. Appropriate Staffing QDDP and Team Leader have implemented a staffing plan which complies with support needs of the home and license allowances. Staff will be trained on the staffing pattern, attendance requirements and procedure for the home that outgoing staff may not leave until oncoming staff have arrived. In addition, Team Leader will address any attendance and tardy issues according to St. Vincent New Hope Policy and Procedure (attached). <i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All individuals in the home have the potential to be affected by these practices. All measures above will apply to all individuals in the home as a systematic corrective procedure change. In addition, Nurse consultant will review all seizure protocols for the other individuals in the home. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i> QDDP will monitor that weekly med counts are completed and provided adequate medication for all residents in home. Nurse Consultant will implement an Abnormal Lab tracking sheet for each individual to monitor lab		

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			values, communication with physician and results. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> St. Vincent New Hope Quality Assurance continues to monitor medication errors monthly, sending a report to Director tracking trends and issues to address. Director will continue to review this report and address medication administration issues with the QDDP of the facility should they occur. Director will also conduct weekly meeting with facility team to monitor corrective measures are effective. IDT will meet monthly to address any ongoing nursing, behavior, social or other issues related to the individuals in the facility. Director will continue to monitor nursing and home charts through random monthly audits.	

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W0331	<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, the facility failed to provide nursing services to meet the needs of 3 of 4 sampled clients and 1 additional client (clients A, E, F, and H). The facility nursing services failed to ensure availability of prescribed medications and failed to correctly transcribe medication orders for client A. The facility nursing services failed to administer medications correctly to clients A, E, F, and H. The facility failed to provide recommended treatment to client A following a fractured toe. The facility failed to ensure all staff were re-trained in procedures for administering medications following discovery of reportable medication errors for client A. The facility failed to ensure medical follow up on abnormal lab values for client A.</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident reports from 03/08/2012 through 05/13/2012 were reviewed on 06/11/2012 at 1:50 p.m.</p>	W0331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Facility practices were reviewed during internal investigation of events from 5/14/12 – 5/21/12. The following measures were implemented to address the deficient practices that were noted during that internal investigation as well as the survey conducted. Client A discharged from the hospital to a skilled nursing facility per guardian request. Client A was discharged from St. Vincent New Hope services on May 28, 2012.</p> <p>Transcribing Medication The nurse consultant team met on 5/16/12 and developed a Procedure for Writing New or Changed Orders and Treatments. It specifies that each new or changed order will be written by a nurse on a medication administration record (MAR) which will then be double checked by an additional nurse or designee for accuracy. The sample MAR will be faxed or delivered to the site. The nurse consultant will then double check the site's MAR that the order was copied from the sample MAR accurately. Nursing team implemented procedure on 5/23/12.</p> <p>Medication Administration</p>	07/13/2012			

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260			
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	<p>1. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/13/2012 at 8:30 a.m., indicated client A did not receive Onfi (medication to treat seizures) 5 mg (milligrams) as prescribed at 8:30 a.m. and 8:30 p.m. on 05/12/2012.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/13/2012 at 8:30 a.m., indicated client A had a seizure lasting more than 15 minutes and required Emergency Medical Services to transport to the hospital for evaluation and treatment.</p> <p>Client A's record was reviewed on 06/13/2012 at 1:50 p.m. A laboratory report, dated 10/21/2011, indicated client A's Dilantin (seizure medication) level was 5.0 (normal = 10-20). The report indicated, "...recheck labs in 1 month..." The record did not indicate the lab was rechecked in a month.</p> <p>A laboratory report, dated 01/17/2012, indicated glucose 123 (normal = 65-99), creatinine (measures kidney function) 0.59 (normal = 0.8-1.3), ALT (liver enzyme) 136 (normal - 0-40), AST (another liver enzyme) 131 (normal =</p>		<p>Medication administration training will occur for all staff at the home. Medication administration observation by the Manager/QDDP (weekly) and the Nurse Consultant (2/mo) will occur and be documented on Medication Observation Sheets. Nursing team reviewed Medication Error procedure and revised to include training to occur by the nurse following a reportable medication error. Procedure also outlines progressive disciplinary action to coincide with retraining attempts.</p> <p>Availability of Medication Team Leader will conduct weekly medication counts to ensure that the appropriate amount of medication is available in the home for administration. Nurse Consultant will conduct a monthly medication count with the TL to ensure adequate supply is on hand and supply nursing oversight to medication count. QDDP will also conduct a monthly med count with the TL, on differing week from nurse consultant, to ensure the adequate supply remains on hand as well as provide additional oversight.</p> <p>Monitoring LabsNursing Department continues to monitor lab values with physician following the Nursing Documentation Procedure. In the event that the physician does not respond, the</p>				

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	<p>0-37). The report indicated, "faxed to [physician]...CBC (complete blood count) 1 x (time) now. Repeat labs in 3 weeks...." The record did not indicate the labs were obtained as requested.</p> <p>Physician's orders, dated 05/01/2012, indicated, "...PHENYTOIN (DILANTIN) 125 MG/5 ML LIQ (liquid) 100 MG, Frequency: THREE TIMES A DAY Instructions: 100 MG = 4 ML...RANITIDINE (ZANTAC used for treatment of esophageal reflux) TAB 150 MG, Frequency: TWICE A DAY...ASCORBIC ACID (antioxidant) TAB: 500 MG, Frequency: WITH BREAKFAST...VITAMIN E (supplement) CAPSULE 200 IU, Frequency: TWICE A DAY...."</p> <p>The MAR, dated 05/01/2012-05/31/2012, indicated, "...(all entries hand written) Onfi 5 mg give one (5 mg) every 12 hours through peg tube *control box*...Phenytoin (Dilantin) 125 mg/5 ml give 30 ml (100 mg) three times daily through peg tube...Ranitidine (Zantac) 150 mg give one twice daily through peg tube...Ascorbic Acid tab 500 mg give one tablet daily with breakfast through peg tube...Vitamin E capsule 200 IU give 400 IU 2 x daily through peg tube...." The MAR indicated incorrect doses of Phenytoin (750 mg instead of 100 mg)</p>		<p>nurse consultant will continue to request a response as indicated in the procedure q 48 hours.</p> <p>Appropriate Staffing QDDP and Team Leader have implemented a staffing plan which complies with support needs of the home and license allowances. Staff will be trained on the staffing pattern, attendance requirements and procedure for the home that outgoing staff may not leave until oncoming staff have arrived. In addition, Team Leader will address any attendance and tardy issues according to St. Vincent New Hope Policy and Procedure (attached). <i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All individuals in the home have the potential to be affected by these practices. All measures above will apply to all individuals in the home as a systematic corrective procedure change. In addition, Nurse consultant will review all seizure protocols for the other individuals in the home. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i> QDDP will monitor that weekly med counts are completed and provided adequate medication for all residents in home.</p>	

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260			
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	<p>were administered at 8:30 a.m., 12:00 p.m., and 9:00 p.m. on 05/02-05/10/2012 and at 8:30 a.m. on 05/11/2012. The MAR indicated Ranitidine was not given at 9:00 p.m. on 05/02/2012 and was not given on at 8:30 a.m. and 9:00 p.m. on 05/03/2012 and 05/04/2012. The MAR indicated the medication was not available for administration. The MAR indicated Onfi was not given on 5/12/2012 at 8:30 a.m. and 9:00 p.m. The record indicated the medication was not available for administration. The MAR indicated Ascorbic acid was not given because it was not available for administration on 05/02/2012-05/12/2012. The MAR indicated Vitamin E was not given at 9:00 p.m. on 05/01-05/03/2012 and was not given at 8:30 a.m. on 05/02-05/04/2012. The record indicated the medication was not available for administration.</p> <p>A radiology report, dated 05/09/2012, indicated client A had a broken right little toe. A hand written note, dated 05/09/2012, indicated, "[Client A] has...a cut on his Right little toe that needs cleaned and bandage changed every shift...." The record did not indicate the bandage was changed after it was applied on 05/09/2012.</p> <p>A hospital social service note dated</p>		<p>Nurse Consultant will implement an Abnormal Lab tracking sheet for each individual to monitor lab values, communication with physician and results.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance continues to monitor medication errors monthly, sending a report to Director tracking trends and issues to address. Director will continue to review this report and address medication administration issues with the QDDP of the facility should they occur.</p> <p>Director will also conduct weekly meeting with facility team to monitor corrective measures are effective.</p> <p>IDT will meet monthly to address any ongoing nursing, behavior, social or other issues related to the individuals in the facility.</p> <p>Director will continue to monitor nursing and home charts through random monthly audits.</p>				

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	<p>05/13/2012 indicated, "...pt (patient) not receiving proper dose of Dilantin...bandage on toe is frayed...Pt did not receive his Onfi today and the medication log shows the medication was unavailable in the house...."</p> <p>An Emergency Record, dated, 05/13/2012, indicated, "...pt w (with) intractable seizures-confusion over medications @ group home. Will admit for further evaluation...."</p> <p>A hospital Discharge Summary, dated 5/31/2012, indicated client A was treated for intractable (hard to control) seizures. The record indicated client A was discharged to a skilled nursing facility.</p> <p>Staff training records were reviewed on 06/13/2012 at 4:30 p.m. The record did not indicate staff were re-trained in medication administration procedures including how to respond to discrepancies between the MAR and the medication labels.</p> <p>2. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/27/2012 at 4:30 p.m., indicated Prilosec (medication used to treat gastroesophageal reflux) 20 mg was not given to client F at 9:00 p.m. on</p>						

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	<p>03/22/2012 and 03/23/2012 as prescribed.</p> <p>Client F's record was reviewed on 06/14/2012 at 9:00 a.m. Physician's orders, dated 03/01/2012-03/31/2012, indicated, "...OMEPRAZOLE (Prilosec for treatment of esophageal reflux) 20 MG GIVE 1 CAPSULE BY MOUTH TWICE DAILY ..."</p> <p>The Medication Administration Record (MAR), dated 03/01/2012-03/01/2012, indicated, Prilosec was not administered at 9:00 p.m. on 03/22 and 03/23/2012.</p> <p>3. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/28/2012 at 9:00 p.m., indicated two doses of client E's antibiotic (Etodolac 300 mg) were omitted on 03/24/2012 and three doses of antibiotic were missed on 03/25/2012.</p> <p>Client E's record was reviewed on 06/12/2012 at 3:45 p.m. A physician's orders, dated 03/24/2012, indicated, "...Etodolac (antibiotic) cap (capsule) 300 mg. Give 1 cap by mouth 3 times a day for 7 days.</p> <p>The MAR, dated, 03/01/2012-03/31/2012, indicated the antibiotic (Etodolac) was not given at 5 p.m. and 9 p.m. on</p>						

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	<p>03/24/2012 and was not given at 7:00 a.m., 5:00 p.m., and 9:00 p.m. on 03/25/2012.</p> <p>4. An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/07/2012 at 7:00 a.m., indicated client H did not receive Levetiraceta (medication to treat seizures) 500 mg as prescribed at 7:00 a.m. on 05/07/2012.</p> <p>Client H's record was reviewed on 06/14/2012 at 9:35 a.m. Physician's orders, dated 05/01/2012-05/31/2012, indicated, "...LEVETIRACETA (seizure medication) TAB 250 MG GIVE 2 TABS (500 MG) BY MOUTH DAILY...."</p> <p>The MAR, dated, 05/01/2012-05/31/2012, indicated Levetiraceta was not given on 05/07/2012.</p> <p>During an interview on 06/11/2012 at 5:45 p.m., Team Leader (TL) #1 indicated it was her responsibility to ensure medications were available in the home for administration. She indicated some medications were not re-ordered because the medication count record had not been updated to reflect all medications prescribed for client A.</p>			

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	<p>During a confidential interview on 06/12/2012 at 7:05 p.m., Confidential Interview (CI) indicated client A did not receive medications for seizure management correctly and indicated client A's bandage on his toe was not changed.</p> <p>During an interview on 06/13/2012 beginning at 10:15 a.m., LPN #1 indicated labs were collected as requested by the physician. She indicated she did not receive or review copies of the labs and did not follow up with the physician in regard to the labs. The nurse stated, "[Client A's] mother took him to his appointments and got copies of the labs." She indicated the facility had not requested copies from the appointments. LPN #1 indicated medications had not been administered correctly to client A on 05/12/2012. She indicated the facility was unable to obtain the correct formula of Dilantin (liquid). She indicated the pharmacist was consulted in regard to equivalency of capsule form verses liquid form of Dilantin. LPN #1 indicated the physician had written an order to use the capsule form of Dilantin until the liquid form was available. A copy of the physician's order was requested but not provided. LPN #1 indicated client A did not receive 750 mg of Dilantin as documented on the MAR for May 1-12, 2012. She indicated the entry on the</p>				

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	<p>MAR was incorrectly transcribed, but given correctly. The nurse indicated DSPs did not consult her in regard to the discrepancies between the entry on the MAR and the label on client A's Dilantin. LPN #1 indicated staff were not re-trained in medication administration following medication errors for client A in May 2012. LPN #1 indicated the order for treatment to client A's right little toe had not been transcribed on the MAR and the treatment was not provided.</p> <p>This federal tag relates to complaint #IN00108415.</p> <p>9-3-6(a)</p>			

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W0368	<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.</p> <p>Based on record review and interview, the facility failed to ensure medications were properly administered to 3 of 4 sampled clients and 1 additional client (clients A, E, F, and H). The facility failed to ensure medications were correctly transcribed on the Medication Administration Record (MAR) for client A.</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident reports from 03/08/2012 through 05/13/2012 were reviewed on 06/11/2012 at 1:50 p.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/27/2012 at 4:30 p.m., indicated Prilosec (medication used to treat gastroesophageal reflux) 20 mg was not given to client F at 9:00 p.m. on 03/22/2012 and 03/23/2012 as prescribed.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services</p>	W0368	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Facility practices were reviewed during internal investigation of events from 5/14/12 – 5/21/12. The following measures were implemented to address the deficient practices that were noted during that internal investigation as well as the survey conducted. Client A discharged from the hospital to a skilled nursing facility per guardian request. Client A was discharged from St. Vincent New Hope services on May 28, 2012.</p> <p>Transcribing Medication</p> <p>The nurse consultant team met on 5/16/12 and developed a Procedure for Writing New or Changed Orders and Treatments. It specifies that each new or changed order will be written by a nurse on a medication administration record (MAR) which will then be double checked by an additional nurse or designee for accuracy. The sample MAR will be faxed or delivered to the site. The nurse consultant will then double check the site's MAR that the order was copied from the sample MAR accurately. Nursing team implemented procedure on 5/23/12.</p>	07/13/2012	

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	<p>incident report, dated 03/28/2012 at 9:00 p.m., indicated two doses of client E's antibiotic (Etodolac 300 mg) were omitted on 03/24/2012 and three doses of antibiotic were missed on 03/25/2012.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/07/2012 at 7:00 a.m., indicated client H did not receive Levetiraceta (medication to treat seizures) 500 mg as prescribed at 7:00 a.m. on 05/07/2012.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/13/2012 at 8:30 a.m., indicated client A did not receive Onfi (medication to treat seizures) 5 mg (milligrams) as prescribed at 8:30 a.m. and 8:30 p.m. on 05/12/2012.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/13/2012 at 8:30 a.m., indicated client A had a seizure lasting more than 15 minutes and required Emergency Medical Services to transport to the hospital for evaluation and treatment.</p>		<p>Medication Administration Medication administration training will occur for all staff at the home. Medication administration observation by the Manager/QDDP (weekly) and the Nurse Consultant (2/mo) will occur and be documented on Medication Observation Sheets. Nursing team reviewed Medication Error procedure and revised to include training to occur by the nurse following a reportable medication error. Procedure also outlines progressive disciplinary action to coincide with retraining attempts.</p> <p>Availability of Medication Team Leader will conduct weekly medication counts to ensure that the appropriate amount of medication is available in the home for administration. Nurse Consultant will conduct a monthly medication count with the TL to ensure adequate supply is on hand and supply nursing oversight to medication count. QDDP will also conduct a monthly med count with the TL, on differing week from nurse consultant, to ensure the adequate supply remains on hand as well as provide additional oversight.</p> <p>Monitoring Labs Nursing Department continues to monitor lab values with physician following the Nursing Documentation Procedure. In the event that the</p>		

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	<p>1. Client F's record was reviewed on 06/14/2012 at 9:00 a.m. Physician's orders, dated 03/01/2012-03/31/2012, indicated, "...OMEPRAZOLE (Prilosec for treatment of esophageal reflux) 20 MG GIVE 1 CAPSULE BY MOUTH TWICE DAILY...."</p> <p>The Medication Administration Record (MAR), dated 03/01/2012-03/01/2012, indicated, Prilosec was not administered at 9:00 p.m. on 03/22 and 03/23/2012.</p> <p>2. Client E's record was reviewed on 06/12/2012 at 3:45 p.m. A physician's orders, dated 03/24/2012, indicated, "...Etodolac (antibiotic) cap (capsule) 300 mg. Give 1 cap by mouth 3 times a day for 7 days.</p> <p>The MAR, dated, 03/01/2012-03/31/2012, indicated the antibiotic (Etodolac) was not given at 5 p.m. and 9 p.m. on 03/24/2012 and was not given at 7:00 a.m., 5:00 p.m., and 9:00 p.m. on 03/25/2012.</p> <p>3. Client H's record was reviewed on 06/14/2012 at 9:35 a.m. Physician's orders, dated 05/01/2012-05/31/2012, indicated, "...LEVETIRACETA (seizure medication) TAB 250 MG GIVE 2 TABS (500 MG) BY MOUTH DAILY...."</p>		<p>physician does not respond, the nurse consultant will continue to request a response as indicated in the procedure q 48 hours.</p> <p>Appropriate Staffing QDDP and Team Leader have implemented a staffing plan which complies with support needs of the home and license allowances. Staff will be trained on the staffing pattern, attendance requirements and procedure for the home that outgoing staff may not leave until oncoming staff have arrived. In addition, Team Leader will address any attendance and tardy issues according to St. Vincent New Hope Policy and Procedure (attached). <i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> All individuals in the home have the potential to be affected by these practices. All measures above will apply to all individuals in the home as a systematic corrective procedure change. In addition, Nurse consultant will review all seizure protocols for the other individuals in the home. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i> QDDP will monitor that weekly med counts are completed and provided adequate medication for all</p>				

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	<p>The MAR, dated, 05/01/2012-05/31/2012, indicated Levetiraceta was not given on 05/07/2012.</p> <p>4. Client A's record was reviewed on 06/13/2012 at 1:50 p.m. Physician's orders, dated 05/01/2012, indicated, "...PHENYTOIN (DILANTIN) 125 MG/5 ML LIQ (liquid) 100 MG, Frequency: THREE TIMES A DAY Instructions: 100 MG = 4 ML...RANITIDINE (ZANTAC used for treatment of esophageal reflux) TAB 150 MG, Frequency: TWICE A DAY...ASCORBIC ACID (antioxidant) TAB: 500 MG, Frequency: WITH BREAKFAST...VITAMIN E (supplement) CAPSULE 200 IU, Frequency: TWICE A DAY...."</p> <p>The MAR, dated 05/01/2012-05/31/2012, indicated, "...(all entries hand written) Onfi 5 mg give one (5 mg) every 12 hours through peg tube *control box*...Phenytoin (Dilantin) 125 mg/5 ml give 30 ml (100 mg) three times daily through peg tube...Ranitidine (Zantac) 150 mg give one twice daily through peg tube...Ascorbic Acid tab 500 mg give one tablet daily with breakfast through peg tube...Vitamin E capsule 200 IU give 400 IU 2 x daily through peg tube...." The MAR indicated incorrect doses of Phenytoin (750 mg instead of 100 mg)</p>		<p>residents in home.</p> <p>Nurse Consultant will implement an Abnormal Lab tracking sheet for each individual to monitor lab values, communication with physician and results.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance continues to monitor medication errors monthly, sending a report to Director tracking trends and issues to address. Director will continue to review this report and address medication administration issues with the QDDP of the facility should they occur.</p> <p>Director will also conduct weekly meeting with facility team to monitor corrective measures are effective.</p> <p>IDT will meet monthly to address any ongoing nursing, behavior, social or other issues related to the individuals in the facility.</p> <p>Director will continue to monitor nursing and home charts through random monthly audits.</p>				

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	<p>were administered at 8:30 a.m., 12:00 p.m., and 9:00 p.m. on 05/02-05/10/2012 and at 8:30 a.m. on 05/11/2012. The MAR indicated Ranitidine was not given at 9:00 p.m. on 05/02/2012 and was not given on at 8:30 a.m. and 9:00 p.m. on 05/03/2012 and 05/04/2012. The MAR indicated the medication was not available for administration. The MAR indicated Onfi was not given on 5/12/2012 at 8:30 a.m. and 9:00 p.m. The record indicated the medication was not available for administration. The MAR indicated Ascorbic acid was not given because it was not available for administration on 05/02/2012-05/12/2012. The MAR indicated Vitamin E was not given at 9:00 p.m. on 05/01-05/03/2012 and was not given at 8:30 a.m. on 05/02-05/04/2012. The record indicated the medication was not available for administration.</p> <p>During an interview on 06/13/2012 beginning at 10:15 a.m., LPN #1 indicated medications had not been administered correctly to client A on 05/12/2012. She indicated the facility was unable to obtain the correct formula of Dilantin (liquid). LPN #1 indicated client A did not receive 750 mg of Dilantin as documented on the MAR for May 1-12, 2012. She indicated the entry on the MAR was incorrectly transcribed.</p>						

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	<p>During an interview on 06/14/2012 at 9:50 a.m., the Qualified Developmental Disabilities Professional indicated medications should have been administered as ordered by the physician for clients A, E, F, and H.</p> <p>This federal tag relates to complaint #IN00108415.</p> <p>9-3-6(a)</p>						