

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/03/2012
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NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 S OAK ST BLUFFTON, IN 46714
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W0000	<p>This visit was for the investigation of complaint #IN00109280.</p> <p>Complaint #IN00109280- SUBSTANTIATED, federal/state deficiencies related to the allegations are cited at W331 and W368.</p> <p>Dates of Survey: June 29 and July 3, 2012.</p> <p>Provider number: 15G469 Facility number: 000983 AIM number: 100244850</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/11/12 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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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, observation and interview, the facility nursing staff failed to establish an effective system to assure medication changes were written correctly on the medication administration record (MAR) in order to preclude medications being administered in error to 4 of 6 clients (clients A, B, C and D) living in the home.</p> <p>Findings include:</p> <p>Records were reviewed on 6/29/12 at 8:38 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports. The reports indicated the following:</p> <p>A BDDS report dated 1/21/12 at 6:30 A.M. indicated "[Client A's] Levothyroxin (thyroid) 50MCG (microgram) tab (tablet) was given instead of her 75MCG tab. The 75 MCG was a new medication that had not been written in the MAR book."</p> <p>A BDDS report dated 1/21/12 at 6:30 A.M. indicated "[Client C's] Levothyroxin 50MCG tab was given instead of her 75MCG tab. The 75 MCG was a new</p>	W0331	<p>W331-Nursing Services Bi-County Services, Inc. (BCS) will provide consumers with nursing services in accordance with their needs. BCS has failed to establish an effective system to assure that medication changes are written correctly on the medication administration record (MAR) in order to prevent medications being administered in error. Our Health Care Monitoring System (HCMS) was established in 2008 to correct a wide variety of health issues and concerns, however, medication errors are of concern and as noted above transcribing orders onto the MAR will be of particular import for this survey plan of correction (POC). It is apparent that we need to re-organize ourselves as an agency to assess and address concerns relating to the assurance that medications and/or treatments are administered in compliance with physician's orders. Two protocols specifically will be developed and implemented to address prevention of errors through directives in a protocol regarding transcribing of new orders/changes on the MAR/TAR. A protocol will also be developed and implemented to clarify specific criteria for the Medication Error Review Team (MERT) to</p>	08/02/2012			

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	<p>medication that had not been written in the MAR book."</p> <p>A BDDS report dated 2/28/12 for 2/16/12 at 7:00 A.M. indicated "[Client A] was taking Benefiber (fiber therapy) 1 (one) tablespoon by mouth in water twice a daily, but the manufacturer no longer makes Benefiber. The new prescription is Citrucel (fiber therapy) 1 tablespoon in 8 (eight) ounces of water QHS (every bedtime). The prescription was written into the MAR correctly; but staff did not follow the change of time and dosage and gave Citrucel according to the old prescription (am & pm). The remainder of the staff followed the incorrect times since 2/16/12 and this medication error was caught this am 2/28/2012...[name of RN] will rewrite the MAR this evening 2/28/12 to show only QHS...."</p> <p>A BDDS report dated 3/23/12 at 9:00 A.M. indicated "On 3/22/12, [client B] missed her 3:00 P.M. dose of Albutol (sic) (asthma). During our medication error investigation process, it was discovered that she had only been receiving albuterol Q8hrs. (every eight hours) instead of every Q6hrs (every six hours) as it was prescribed. The order was written wrong on the MAR. The dates that [client B] received the wrong dose of albutol (sic) were 3/12/12, 3/13/12,</p>		<p>address ongoing monitoring and quality assurance. Corrective action and follow-up specific to Consumers A, B, C and D: Consumer A: 1. Consumer A does not take any thyroid medications and there is no BDDS Incident Report (IR) related to Levothyroxin for Consumer A. 2. BDDS IR dated 2/28/12 for error relating to change in medication from Benefiber given twice daily in the am & pm was discontinued and new medication of Citrucel one (1) tablespoon by mouth in eight ounces of water QHS was to be started on 2/16/12. The order was written correctly in the MAR, but staff did not follow the order as written. For twelve days she was given the Citrucel twice daily as had been the order for the Benefiber. Seven staff was responsible for errors during this time frame. Her personal care physician (PCP) was contacted at the time the error was discovered by nursing staff and there were no harmful side effects as a result of the error. Residential Management Team (RMT) provided re-training to Oak staff on reading a new script and administering according to physician's orders at any time there is a change in medications and/or new medications are prescribed. There have been no further medication errors for Consumer A since that time. A protocol will be developed and</p>				

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	<p>3/17/12, 3/18/12, 3/19/12, 3/20/12, 3/21/12, 3/22/12, & 3/23/12...."</p> <p>A BDDS report dated 5/1/12 at 11:00 A.M. indicated "From 4/14/12 to 5/1/12, [client D] had been given Aspirin (blood thinner) 81mg (milligrams) 2 (two) tab 1x (one time) daily when she was suppose (sic) to be given Aspirin 81mg 1 tab 2 x's daily. The script was written in wrong on MAR."</p> <p>Observations were conducted at the group home on 6/29/12 from 6:31 A.M. until 8:03 A.M. including a medication pass. During the medication pass the current MAR for client A was reviewed and indicated on a yellow 2" x 2" (two inch by two inch) sticky note "Just give 1 pill which is 50mg since the new dosage is 25mg" The note was located on the MAR next to the order for Topiramate (generic for Topamax) for seizures. The note did not indicate which medication was indicated. Client B's medications/ MAR were also reviewed during the medication pass. Client B had a bottle of Carbamazepine (mood stabilizer) with a label indicating she was to take 5 (five) ML (milliliters) BID (twice a day). The MAR for client B indicated she was to take 3 (three) ML BID.</p> <p>Direct Care Staff (DCS) #1 was</p>		<p>implemented focusing on transcribing new and/or changes in medication orders. 3. During an AM medication pass observation by the surveyor on 6/29/12 the MAR was reviewed and indicated that for consumer A's seizure medication (Topamax) there was a "sticky note" providing instructions regarding number of pills to be administered. The note did not indicate what med the instructions were for, although it was located by the Topamax order. On 7/1/12, the note was revised to clarify the medication as Topamax. Effective 7/19/12, at pharmacy cycle fill, the order for the Topamax is now reflected on the Blister Pak and MAR. Consumer B: 1. IR dated 3/23/12 indicated an error in transcribing medication orders on the MAR for consumer B's Albuterol resulting in errors for nine days. The order was to receive the Albuterol every six hours during waking hours. The error was that the Albuterol was given every eight hours during waking hours. Staff who wrote the error incorrectly on the MAR was suspended from passing medications until re-trained on how to properly write scripts on the MAR. All staff working at the Oak group home was re-trained on proper way to write an order onto the MAR, as well as the Six Rights of Medication Administration. Agency RN contacted consumer B's PCP and</p>				

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	<p>interviewed on 6/29/12 at 7:26 A.M.. DCS #1 indicated the medication (Topamax) change for client A had occurred on 6/26/12, and they were just using up the last of the pills before the new month started. DCS #1 stated "[Client A's] new prescription was 25mg tablets and she was to take two (50 mg) in the morning, and three (75 mg) at night." DCS #1 stated "[Client B's] MAR was correct." DCS #1 stated the order for (client B) had "changed more than a month ago." DCS #1 stated there was a "change of medication sticker on the bottle."</p> <p>The facility RN was interviewed on 6/29/12 at 10:05 A.M.. The RN stated "Whoever takes the client to the doctor and gets a medication change or new order is responsible for writing the new order on the MAR." The RN indicated it is then checked by buddy checks, the overnight staff, residential manager, and the nurses check it monthly.</p> <p>A review of staff training documentation dated 4/2/12 was completed on 7/3/12 at 9:25 A.M. and indicated DCS were trained on "Proper MAR documentation. All staff given a competency on writing new orders in. Initialing new order, buddy check new order written in."</p>		<p>there were no adverse reactions for the consumer, however the recommendation for follow-up (F/U) by the PCP was to give the Albuterol every six hours as originally ordered. The Albuterol is now prn for shortness of breath. As noted in item #2 for consumer A, a protocol will be developed and implemented for transcribing orders to the MAR as per physician's orders to ensure prevention of medication errors.</p> <p>2. During an AM medication pass observation by the surveyor on 6/29/12 consumer B had a bottle of Carbamazepine with a label indicating she was to take five ML (milliliters) BID. The MAR for consumer B indicated that she was to take three (3) ML BID. There was a "change of medication" label sticker on the bottle. Consumer C: 1. BDDS IR dated 1/21/12 indicated that Consumer C's Levothyroxin (for hypothyroidism) 50 microgram (MCG) tab was given instead of her 75 MCG tab. The 75 MCG was a new medication order that was not transcribed onto the MAR in a timely manner nor did staff follow the Medication Delivery Protocol. Agency RN instructed that the 75 MCG be started on 1/22/12 as consumer C had already taken 50 MCG at AM med pass. There were no adverse reactions for consumer C as a result of this error. All staff was re-trained on receiving and processing any medication(s)</p>				

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	<p>This federal tag relates to complaint #IN00109280.</p> <p>9-3-6(a)</p>		<p>dropped off by YAH pharmacy on 1/23/12. Again, as noted for consumers A & B, a protocol on transcribing new/changes in orders will be developed and implemented in order to prevent future errors. There have been no medications errors since 1/21/12 for consumer C. Consumer D: 1. Upon review of the BDDS IR dated 5/1/12 which stated that "from 4/14/12 to 5/1/12 that consumer D had been given Aspirin 81 mg (blood thinner for history of stroke) 2 tabs once daily when the order was for Aspirin 81 mg 1 tab twice daily. The script was written wrong on the MAR". The MAR indicates that the order is indeed for Aspirin 81 mg 2 tabs daily effective 4/16/12. Agency RN contacted Consumer D's PCP and was told that there would be no adverse reactions as a result of the aspirin 81 mg 1 tab being given twice daily. Effective 5/1/12 the medication is being given as per order. There have been no further medication errors for Consumer D. Again, the need for a protocol addressing transcribing and checking orders thoroughly to assure that they are in compliance with physician's orders will be developed and implemented. Person's responsible: RN's & Medical Caseworker; RMT's, Program Director (PD), Residential Administrator (RA) and Administrative Assistant for</p>	

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			<p>Quality Assurance (AAQA). Target Completion Date: 8/2/12 Corrective action as it relates to nursing services and prevention of medication errors as a result of transcribing physician's orders on MAR accurately for Oak and agency wide: 1. A protocol will be developed and implemented to address transcribing of new orders &/or medication changes to the MAR/TAR as per physician's orders to prevent errors. 2. A protocol will be developed and implemented to clarify specific criteria for the MERT to address ongoing monitoring and quality assurance. 3. Staff is encouraged to utilize the Medical On-Call system for questions and clarification after business hours. We are looking into a Fax to email system for staff to provide Medical On-Call with changes in medication information using the Medical On-Call iPad. As a safeguard, copies of any orders, MAR documentation due to medication changes and the Med Pass/Buddy- Check "Check Off" sheet will be sent to the medical department the next business day for review and clarification when appointments are completed by staff other than medical personnel, especially on weekends or afternoon business hours. This "copy" system will be used until the FAX to email system is up and running. 4. BCS is looking into the benefits of</p>		

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			<p>an electronic medication pass system using eMAR's. 5. The Oak staff will be trained and competency tested on the new protocols, 6 rights of med administration and Buddy Checks. Any staff that cannot pass the competency test at 90% or above will be pulled from passing medications until it is demonstrated that they have the competency to pass medications without error and/or go back through the Living in the Community Core A & B. Disciplinary action will be considered when reviewing errors in the future, should there be any. 6. All staff working with group home consumers across all settings will be trained on the new protocols by 8/2/12. 7. RM's will monitor MAR/TAR's on days that they work and 3rd shift staff checks the MAR/TAR's daily. Any problems noted will be investigated by the RMT and F/U done to address any problems in a timely manner. 8. Supported Living Management Teams (SLMT) will be trained on the new protocols by 8/2/12 and they in turn will train SL staff working with waiver consumers. Person's Responsible: RN's & Medical Caseworker; RMT's; RA; AAQA and PD. Target Completion Date: 8/2/12</p>		

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W0368	<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.</p> <p>Based on record review and interview, the facility failed to assure medications were administered in compliance with the physician's orders for 3 of 6 clients (clients A, B and D) living in the home.</p> <p>Findings include:</p> <p>Records were reviewed on 6/29/12 at 8:38 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports. The reports indicated the following:</p> <p>A BDDS report dated 2/28/12 for 2/16/12 at 7:00 A.M. indicated "[Client A] was taking Benefiber (fiber therapy) 1 (one) tablespoon by mouth in water twice a daily, but the manufacturer no longer makes Benefiber. The new prescription is Citrucel (fiber therapy) 1 tablespoon in 8 (eight) ounces of water QHS (every bedtime). The prescription was written into the MAR correctly; but staff did not follow the change of time and dosage and gave Citrucel according to the old prescription (am & pm). The remainder of the staff followed the incorrect times since 2/16/12 and this medication error</p>	W0368	<p>W368-Drug Administration Bi-County Services, Inc. will have an organized system for drug administration that assures that all medications are administered in compliance with physician's and are administered without error. For this POC the component of transcribing orders correctly onto the MAR/TAR to prevent errors is the priority. This is not an excuse but rather a statement of fact that with the increase in number of medications and treatments ordered by health care professionals it has become apparent that we need to re-organize ourselves as an agency to assess and address concerns relating to the assurance that medications and/or treatments are administered in compliance with physician's orders and without error. The corrective action for three of the Oak residents as well as the systemic changes to ensure that deficient practices do not recur are the same as noted in the W331 tag. Corrective Action and follow-up specific to Consumers A, B and D: Consumer A: Reference W331 Consumer A-item #2. Consumer B: Reference W331 Consumer B-item #1 Consumer D:</p>	08/02/2012	

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	<p>was caught this am 2/28/2012...[name of RN] will rewrite the MAR this evening 2/28/12 to show only QHS...."</p> <p>A BDDS report dated 3/23/12 at 9:00 A.M. indicated "On 3/22/12, [client B] missed her 3:00 P.M. dose of Albutrol (sic) (asthma). During our medication error investigation process, it was discovered that she had only been receiving albuterol Q8hrs. (every eight hours) instead of every Q6hrs (every six hours) as it was prescribed. The order was written wrong on the MAR. The dates that [client B] received the wrong dose of albutrol (sic) were 3/12/12, 3/13/12, 3/17/12, 3/18/12, 3/19/12, 3/20/12, 3/21/12, 3/22/12, & 3/23/12...."</p> <p>A BDDS report dated 5/1/12 at 11:00 A.M. indicated "From 4/14/12 to 5/1/12, [client D] had been given Aspirin (blood thinner) 81mg (milligrams) 2 (two) tab 1x (one time) daily when she was suppose (sic) to be given Aspirin 81mg 1 tab 2 x's daily. The script was written in wrong on MAR."</p> <p>The facility RN was interviewed on 6/29/12 at 10:05 A.M.. The RN stated "Whoever takes the client to the doctor and gets a medication change or new order is responsible for writing the new order on the MAR." The RN indicated it</p>		<p>Reference W331 Consumer D-item # Persons responsible: RN's & Medical Caseworker, RMT's, RA, PD and AAQA Target completion date: 8/2/12 Corrective action as it relates to Medication Administration practices agency wide" Reference W331 corrective action relating to prevention of medication errors items #1-8. Persons responsible: RN's & Medical Caseworker; RMT's, RA, PD & AAQA. Target completion date: 8/2/12</p>				

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	<p>is then checked by buddy checks, the overnight staff, residential manager, and the nurses check it monthly.</p> <p>An interview was conducted with the Director of Residential Services (DRS) on 6/29/12 at 8:55 A.M.. When asked about the medication errors at the group home, the DRS stated "We have had a Residential Manager and a QMRP (qualified mental retardation professional) turn over at the home just this past year." The DRS stated they had been tracking the medication errors and "had found some patterns, would work on correcting those and then a new issue would arise."</p> <p>This federal tag relates to complaint #IN00109280.</p> <p>9-3-6(a)</p>				