

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2012
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NAME OF PROVIDER OR SUPPLIER  KNOX COUNTY ARC-ARC AVE (105)	STREET ADDRESS, CITY, STATE, ZIP CODE 2968 E ARC AVE BLDG 105 VINCENNES, IN 47591
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W0000	<p>This visit was for the investigation of complaint #IN00104180.</p> <p>Complaint #IN00104180-Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154 and W331.</p> <p>Dates of Survey: 3/6, 3/7, 3/8 and 3/12/12</p> <p>Facility Number: 002937 Provider Number: 15G693 Aim Number: 200333060</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/14/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 2 of 4 sampled clients (A and B), the governing body failed to ensure facility staff did not neglect clients in regard to a medication error. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported allegations of neglect timely and/or failed to ensure the facility conducted investigations in regard to all allegations of neglect.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 4 sampled clients (A and B). The governing body failed to implement its policy and procedures to prevent neglect of clients in regard to significant medication errors. The governing body failed to implement its policy and procedures to conduct thorough investigations and to ensure ensure medication errors which could affect the welfare of clients were reported immediately to the administrator.</li> <li>The governing body failed to</li> </ol>	W0102	<p>W102</p> <p>Plan of Correction: A thorough investigation will be completed on the incident involving an allegation of neglect on Client B. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator.</p> <p>Preventive Action: All members of the Investigation Team will be retrained by the Vice President of Program Services on reporting and investigating all allegations of abuse/neglect. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator. The Director of Residential Services and/or the Director of Health Services will retrain the Manager</p>	04/11/2012			

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	<p>implement its written policies and procedures to prevent neglect of clients in regard to medication errors which caused harm to the clients. The governing body failed to implement its policy and procedures to ensure facility staff reported significant medication errors and/or conducted/documentated a thorough investigation in regard to the medication errors for clients A and B.</p> <p>The governing body failed to ensure facility staff reported significant medication errors to the administrator immediately for clients A and B.</p> <p>The governing body failed to conduct a thorough investigation in regard to an allegation of neglect which was made during the investigation of a significant medication error for client B. Please see W104.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>9-3-1(a)</p>		<p>and Coordinator. The Manager and/or Coordinator will retrain the Assistant Manager and direct care staff.</p> <p>Monitoring: The Administrative Assistant will monitor that thorough investigations are completed on all allegations of abuse/neglect. The Manager and/or Assistant Manager will be in the home when consumers are present at least 5 days per week. During this time, the Manager and/or Assistant Manager will frequently remind staff of reporting procedures for abuse/neglect. "KCARC Procedures for Reportable Incidents" will be placed in the home in a location where staff can easily access it. A nurse, Manager, Assistant Manager or Medical Assistant will monitor at least one medication pass per week. The Vice President of Program Services, the Director of Residential Services and the Director of Health Services will monitor that all above mentioned tasks/requirements are implemented by the required due date.</p> <p>Date to be Completed By: April 11, 2012 Responsible Party: Vice President of Program Services, Director of Residential Services, Director of Health Services</p>		

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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 interview and record review for 2 of 4 sampled clients (A and B), the governing body failed to exercise general policy and operating direction over the facility to ensure facility staff did not neglect clients in regard to a medication error. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported allegations of neglect timely and/or failed to ensure the facility conducted investigations in regard to all allegations of neglect.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent neglect of clients in regard to medication errors which caused harm to the clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure facility staff reported significant medication errors, and/or conducted/documented a thorough investigation in regard to the medication</p>	W0104	<p>W104</p> <p>Plan of Correction: A thorough investigation will be completed on the incident involving an allegation of neglect on Client B. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator. All direct care staff will be retrained on reporting all significant medication errors to the Nurse Pager immediately.</p> <p>Preventive Action: All members of the Investigation Team will be retrained by the Vice President of Program Services on reporting and investigating all allegations of abuse/neglect. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the</p>	04/11/2012			

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	<p>errors for clients A and B. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility staff reported significant medication errors to the administrator immediately for clients A and B. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to an allegation of neglect which was made during the investigation of a significant medication error for client B. Please see W154.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>9-3-1(a)</p>		<p>Designated Administrator. All direct care staff, Managers and Coordinator will be retrained on reporting medication errors to the Nurse Pager immediately. The Director of Residential Services and/or the Director of Health Services will retrain the Manager and Coordinator. The Manager and/or Coordinator will retrain the Assistant Manager and direct care staff.</p> <p>Monitoring: The Administrative Assistant will monitor that thorough investigations are completed on all allegations of abuse/neglect. The Manager and/or Assistant Manager will be in the home when consumers are present at least 5 days per week. During this time, the Manager and/or Assistant Manager will frequently remind staff of reporting procedures for abuse/neglect. "KCARC Procedures for Reportable Incidents" will be placed in the home in a location where staff can easily access it. A nurse, Manager, Assistant Manager or Medical Assistant will monitor at least one medication pass per week. The Vice President of Program Services, the Director of Residential Services and the Director of Health Services will monitor that all above mentioned tasks/requirements are implemented by the required due date.</p>				

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (A and B). The facility failed to implement its policy and procedures to prevent neglect of clients in regard to significant medication errors. The facility failed to implement its policy and procedures to conduct thorough investigations and to ensure ensure medication errors which could affect the welfare of clients were reported immediately to the administrator.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policies and procedures to prevent neglect of clients in regard to medication errors which caused harm to the clients. The facility failed to implement its policy and procedures to ensure facility staff reported significant medication errors and/or conducted/documentated a thorough investigation in regard to the medication errors for clients A and B. Please see W149.</p> <p>2. The facility failed to ensure facility staff reported significant medication</p>	W0122	<p>W122</p> <p>Plan of Correction: A thorough investigation will be completed on the incident involving an allegation of neglect on Client B. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator. All direct care staff will be retrained on reporting all significant medication errors to the Nurse Pager immediately.</p> <p>Preventive Action: All members of the Investigation Team will be retrained by the Vice President of Program Services on reporting and investigating all allegations of abuse/neglect. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator. All</p>	04/11/2012	

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	<p>errors to the administrator immediately for clients A and B. Please see W153.</p> <p>3. The facility failed to conduct a thorough investigation in regard to an allegation of neglect which was made during the investigation of a significant medication error for client B. Please see W154.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>9-3-2(a)</p>		<p>direct care staff, Managers and Coordinator will be retrained on reporting medication errors to the Nurse Pager immediately. The Director of Residential Services and/or the Director of Health Services will retrain the Manager and Coordinator. The Manager and/or Coordinator will retrain the Assistant Manager and direct care staff.</p> <p>Monitoring: The Administrative Assistant will monitor that thorough investigations are completed on all allegations of abuse/neglect. The Manager and/or Assistant Manager will be in the home when consumers are present at least 5 days per week. During this time, the Manager and/or Assistant Manager will frequently remind staff of reporting procedures for abuse/neglect. "KCARC Procedures for Reportable Incidents" will be placed in the home in a location where staff can easily access it. A nurse, Manager, Assistant Manager or Medical Assistant will monitor at least one medication pass per week. The Vice President of Program Services, the Director of Residential Services and the Director of Health Services will monitor that all above mentioned tasks/requirements are implemented by the required due date.</p> <p>Date to be Completed By: April</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2012  
FORM APPROVED  
OMB NO. 0938-0391

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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.</p> <p>Based on interview and record review for 2 of 4 sampled clients (A and B), the facility neglected to implement its written policies and procedures to prevent neglect of clients in regard to medication errors which caused harm to the clients. The facility neglected to implement its policy and procedures to ensure facility staff reported significant medication errors and/or conducted/documentated a thorough investigation in regard to the medication errors.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/7/12 at 11:09 AM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-2/17/12 at 9:20 PM, "On 02-19-12 at approximately 8:11 a.m., [staff #3] (staff) reported that she was asked on 02-17-12 at approximately 9 p.m. to give medications to [client A] after another staff (staff #2) had prepared the medications. She reported that she gave two separate doses to [client A] after being asked to do so. She thinks [client</p>	W0149	<p>Plan of Correction: A thorough investigation will be completed on the incident involving an allegation of neglect on Client B. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator. All direct care staff will be retrained on reporting all significant medication errors to the Nurse Pager immediately.</p> <p>Preventive Action: All members of the Investigation Team will be retrained by the Vice President of Program Services on reporting and investigating all allegations of abuse/neglect. All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the</p>	04/11/2012			

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	<p>A] may have gotten someone else's medications one of those times. Both staff involved were immediately suspended pending the outcome of an investigation. An investigation began immediately. [Client A's] physician will be made aware of the possible error. Every attempt is being made to determine whose medications [client A] possible received."</p> <p>-2/17/12 at 9:00 PM, "It was reported on 02-19-12 that [client B] did not receive his 8 p.m. and 9 p.m. meds on 2-17-12. These medications include: Gabitril (seizure) 16mg (milligrams), Trazodone (behavior) 100mg, Certavite-Antioxidant (supplement), Castor Oil (constipation) 10cc (cubic centimeters) and Divalproex Sodium ER (Extended Release) (seizure) 500mg (2 tablets). [Client B] has experienced no known harmful reastions (sic)/effects from missing these medications. Staff was suspended pending the outcome of an investigation. An investigation began immediately. Other staff were advised to report any concerns to the nurse immediately."</p> <p>-2/18/12 at 11:30 AM, "...[Client A] was taken by ambulance to the Emergency Room (ER) at [name of hospital] in [name of city]. IN (Indiana). She was sent to the ER because she was not</p>		<p>Designated Administrator. All direct care staff, Managers and Coordinator will be retrained on reporting medication errors to the Nurse Pager immediately. The Director of Residential Services and/or the Director of Health Services will retrain the Manager and Coordinator. The Manager and/or Coordinator will retrain the Assistant Manager and direct care staff.</p> <p>Monitoring: The Administrative Assistant will monitor that thorough investigations are completed on all allegations of abuse/neglect. The Manager and/or Assistant Manager will be in the home when consumers are present at least 5 days per week. During this time, the Manager and/or Assistant Manager will frequently remind staff of reporting procedures for abuse/neglect. "KCARC Procedures for Reportable Incidents" will be placed in the home in a location where staff can easily access it. A nurse, Manager, Assistant Manager or Medical Assistant will monitor at least one medication pass per week. The Vice President of Program Services, the Director of Residential Services and the Director of Health Services will monitor that all above mentioned tasks/requirements are implemented by the required due date.</p>		

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	<p>responsive to staff. She was awake, but did not respond when people spoke to her. Her pulse rate was 44. [Client A] was transported from [name of hospital] to [name of another hospital] IN (sic) [name of another city], IN on 2-18-12. She was taken by ambulance and admitted to [name of hospital]...."</p> <p>The facility's 2/20/12 follow-up report indicated "The allegations of neglect were substantiated because [staff #3] and [staff #2] caused [client A's] medication errors by not following KCARC's Medication Policy. The hospital concluded that she was hospitalized on 2-18-12 because of the errors on 2-17-12. Also [staff #3] and [staff #2] failed to report the medication errors immediately. [Staff #3] and [staff #2] were terminated on 2-20-12. All remaining staff in the home was (sic) retrained on the appropriate procedures for passing medications and abuse/neglect on 2-20-12."</p> <p>-2/19/12 at 4:00 PM, "...[Client B] had a seizure that lasted more than 5 minutes. He had an order of Diastat (medication used to stop seizures), but it was not used because the ambulance had already been called. The ambulance was called because the seizure was atypical. The staff will be trained on the administration of Diastat."</p>		<p>Date to be Completed By: April 11, 2012 Responsible Party: Vice President of Program Services, Director of Residential Services, Director of Health Services</p>				

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	<p>The facility's 2/20/12 follow-up report indicated "...It is logical to conclude that [client B] had a seizure on the 19th because he missed his seizure medication on the 17th...." The 2/20/12 follow-up report indicated staff #2 and #3 neglected to follow the facility's policy and procedures in regard to medication administration and failed to report the medication errors immediately.</p> <p>The facility's 2/20/12 Investigation Summaries, for the 2/17/12 to 2/19/12 incidents, indicated client A and B's trips to the ER and/or hospitalization were due to the 2/17/12 medication errors at the 9 PM medication pass. The facility's investigation summaries indicated "...Because the ambulance arrived prior to the seizure lasting five minutes, Diastat was not administered (for client B)...." The facility's investigation summary indicated "...The medication errors were not reported until after [client A] was already in the hospital. The hospital was notified of the errors. Neither [staff #2] nor [staff #3] denied the allegations against them. [Client A] remains in the hospital but is recovering quickly and is just currently being kept for observation. The hospital reported to [administrative staff #1] on 2-19-12 that [client A's] condition was due to the medication</p>						

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	<p>errors. No staff besides [staff #3] and [staff #2] were aware of the errors until [staff #3] reported them on the morning of 2-19-12...."</p> <p>Staff #3's 2/19/12 facility's witness statement and/or the 2/19/12 County Sheriff Department Voluntary Statement indicated staff #3 was getting client A ready to take her shower when staff #2 asked staff #3 to give client A her medications (Topiramate 25 mg-seizures, Metoclopramide 5 mg-Gastroesophageal Reflux Disease (GERD) and Levothyroxine 125 micrograms-thyroid) since client A was undressed in the bathroom. The 2/19/12 witness statements indicated staff #3 was asked by staff #2, a second time, to administer client A's 9 PM medications to the client. The 2/19/12 witness statements indicated "...As I was giving [client A] her meds, I remembered that I have already given her, her 9 pm medications (sic). That's when I told [staff #2] he gave me somebody else's meds."</p> <p>Staff #2's 2/19/12 facility's witness statement and/or the 2/19/12 County Sheriff Department Voluntary Statement indicated "At 8:30 I began Med Pass-I remember [client D] was first in getting her meds- It was kind of a wild night. I remember [staff #3] asking me if I had</p>						

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	<p>given [client A's] meds twice and if everyone had been given their meds And (sic) I thought I Remembered (sic) giving everyone their Meds- We looked through the MARS (Medication Administration Records) and it all seemed ok. I remember giving [client B] his meds but it must have been 5:00. I remember I gave 5:00 Meds Also (sic). I (staff #2) asked (staff #3) to carry meds-cause my feet were hurting so bad I could hardly stand let alone walk back of the house (sic)."</p> <p>Client A's hospital records were reviewed on 3/7/12 at 4:05 PM and on 3/8/12 at 8:00 AM. Client A's 2/18/12 hospital's Nurses Notes Triage data indicated client A was sent to the ER due to "Mental Status Change." The 2/18/12 triage note indicated client A was "pale" and had "weak pulses" in all her extremities and had diminished "Hypo" bowel sounds. The 2/18/12 nurse assessment/notes indicated client A had "shallow labored" breath sounds with "retractions" and "Rhonci Anterior upper lobes." Client A's 2/18/12 Nursing Narrative indicated "...Staff states that she (client A) was normal for self last night &amp; (and) that when she awoke today she was not speaking (with) unresponsiveness. Pt (patient) stares blankly (with) no response to movement, repositioning, verbal</p>						

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	<p>stimulus...Breathing slightly labored on 6L (liter) NC (nasal ?) 0 (zero) tracking noted. No movement noted in ext (extremities) spontaneously or on command. Extremities flaccid...." No reaction during Foley placement...0 reaction to blood draw...." The 2/18/12 nursing narrative indicated client A was transferred by ambulance to another hospital for neurological evaluation and treatment in a different city.</p> <p>Client A's 2/19/12 History and Physical (H &amp; P) indicated "...She (client A) was transferred here from [name of hospital] for further neurological evaluation. On arrival she is awake and attending to both sides but is non-verbal with intermittent jerking mvt (movement) of her face and upper extremities. The H &amp; P indicated "Altered Mental Status: most likely seizure vs cerebral ischemia with history of epilepsy as a child. Though also could be side effects of several home medications...." Client A's 2/19/12 Hospital Progress Note by a doctor indicated "...It was reported that pt received several sedating medications in error at the group home prior to arrival." The 2/19/12 progress note indicated "...Hopefully pt will improve as medications wear off...." A 2/20/12 progress note by a nurse practitioner indicated "...Altered Mental</p>						

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	<p>Status-resolved: most likely seizure with history of epilepsy as a child. Was also informed pt received multiple sedative medications in error from the group home which could have been contributing factor...."</p> <p>Client A's 2/21/12 Discharge Summary indicated the client was admitted to the Neurological Intensive Care Unit upon arrival to the second hospital and "loaded with Keppra 1000mg (seizure) and then transitioned to 250mg orally BID (two times a day). She was noted to have active seizure activity on admission which resolved with Keppra. The etiology of the seizure is unknown and may have been multi factorial with over medication (received someone elses (sic) medication in error at group home in addition to her medications), UTI (Urinary Tract Infection), hypothyroidism, and with prior hx (history) of seizures as a child...."</p> <p>Client A's record was reviewed on 3/7/12 at 2:05 PM. Client A's 2/12 physician's orders indicated client A's diagnoses included, but were not limited to, Hypothyroidism, GERD and history of seizures, Depression and Asthma. Client A's 2/9/12 Change in Medication Report indicated client A received oxygen 4 liters at night due to low oxygen levels. Client A's 2/12 physician's orders indicated</p>						

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	<p>client A's oxygen saturation levels were monitored 3 times a day.</p> <p>Client A's February 2012 monthly nurse note indicated on 2/18/12, "Consumer sent to [initials of hospital] er due to being over medicated. Consumer was then transported to [name of hospital] for observation...."</p> <p>Client A's 6/6/11 Risk Issues indicated "1. Consumer has not experienced a seizure while at KCARC...." Client A's 7/8/98 typed neurological note indicated client A's last documented seizure was in July of 1998. Client A's record did not indicate any documentation of a seizure since 1998.</p> <p>Client B's record was reviewed on 3/7/12 at 1:24 PM. Client B's 2/19/12 Emergency Room Note indicated client B was seen in the ER due to seizures. The 2/19/12 ER note indicated labs were conducted in regard to client B's seizure medications. The 2/19/12 note indicated "Carbamazepine (seizure) level was less than 0.1 Valporic acid (seizure) level was less than 0.1. According to the group home record, he is taking his medication...According to group home record, he is getting this medicine but according to his labs it does not look like he is actually ingesting this...Impression:</p>						

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	<p>Breakthrough seizure, exact etiology unclear, it appears that he is not getting this medication." Client B's 2/19/12 labs indicated client B's Tegretol (Carbamazepine) level was "L" (low) &lt; (less than) 2.0 with a normal range being 8.0 to 12.0. Client B's 2/19/12 lab for Depakene (Valporic Acid/Divalproex) was "L" &lt; 10.0 with a normal range being 50.0 to 100.0.</p> <p>Client B's 2/12 physician's order indicated client B's diagnosis included, but was not limited to, Major Epilepsy. Client B's 2/20/12 faxed note to client B's doctor at 12:55 PM indicated the facility's nurse was faxing the client's doctor to obtain an order for labs "...due to recent seizure activity." The 2/20/12 faxed note indicated client B's doctor documented "Is he the one that was seen in ER-They did not show he was taking his meds. What are his seizure meds. They need to be ordered specifically. Make sure he takes his meds." A second 2/20/12 faxed note from the client's nurse to client B's doctor at 4:42 PM, indicated client B "Missed all evening doses on 2/17/12 &amp; had a seizure on 2/19 @ (at) around 3 pm. He received all meds between that time." Client B's doctor's response at the bottom of the faxed note indicated "Give meds as Directed &amp; wait 2 weeks-Then do Depakote; Tegretol &amp; Keppra</p>						

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	<p>level...Make sure he is swallowing meds &amp; not spitting out later. ER told me his levels were '0'."</p> <p>Client B's 2/12 monthly nursing note indicated the following (not all inclusive):</p> <p>-2/19/12 "Consumer sent to er for seizure activity. Labs drawn and levels appeared to be low. Seizure stopped and consumer sent home. Appts (appointments) made with pcp (primary care physician) and neuro (neurologist)."</p> <p>2/21/12 "Spoke with [name of neurologist] office about lab work done at er. New labs ordered for cbc,chem14,serum, tegretol,depakene,gabitril, and keppra (all seizure meds) (sic)." The 2/21/12 nurse note neglected to include any additional documentation/conversation with the neurologist in regard to the client's low levels.</p> <p>Client B's record and/or 7/29/11 Individual Support Plan neglected to indicate client B's interdisciplinary team (IDT) met to discuss and/or address client B's doctor's concerns and/or recommendation in regard to ensuring the client received his medications. The facility's 2/20/12 Investigation Summary neglected to address and/or include</p>						

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	<p>additional information/investigation and/or documentation in regard to the allegation of client B not receiving his seizure medications due to the low levels of client B's seizure medications.</p> <p>Client B's 12/2/11 Seizure Description Record indicated client B's last documented seizure was on 12/2/11. The 12/2/11 seizure record indicated "He had a petit mal seizure. His mouth would draw in when he breathed and his hands were drawn in...." Client B's record indicated the facility neglected to document client B's 2/19/12 seizure which resulted in a trip to the ER.</p> <p>Client B's 1/5/12 physician's order indicated client B received "Diastat Accudial 5-7.5 to 10 mg rectally PRN (as needed) for seizures." Client B's 8/1/11 Risk Issues indicated client B had a nursing protocol/risk plan for seizures. The 8/1/11 risk plan indicated the following (not all inclusive):</p> <p>"1. Continue medications as prescribed by physician. 2. Follow Seizure Protocol Plan in place. 3. Nurse will monitor labs as ordered by physician and report abnormal values to physician...5. Report any seizure activity to nurse and complete Seizure Description form...." Client B's 8/1/11 seizure risk plan neglected to</p>				

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	<p>include and/or indicate a risk plan for the use of the PRN Diastat.</p> <p>The facility's inservice training records were reviewed on 3/8/12 at 2:20 PM. The facility's 11/14/11 Employee Training Record indicated facility staff were trained on Diastat Administration on 11/14/11.</p> <p>Interview with staff #1 on 3/6/12 at 9:10 PM indicated facility staff were not to pre-set up medications and/or administer medications and have other staff pass the medications. Staff #1 indicated facility staff had been retrained in regard to medication administration 2 weeks ago.</p> <p>Interview with administrative staff #1, administrative staff #2, LPN #1 and the Qualified Mental Retardation Professional-Designee (QMRP-D) on 3/8/12 at 11:44 AM indicated client A went to the hospital on 2/18/12 and client B was sent out to the ER on 2/19/12 for a seizure which lasted over 5 minutes. QMRP-D indicated Diastat was not used as 911 was called. Administrative staff #2 stated client B's seizure on 2/19/12 was not his "typical seizure." LPN #1 indicated client B's neurologist stated client B's low Tegretol and Depakote levels were "probably a lab mix-up." LPN #1 indicated client B's primary care</p>						

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	<p>doctor was concerned about the client's low levels and was concerned client B was not getting his medication. LPN #1 indicated she did not document what the neurologist said to her. Administrative staff #1 and #2 indicated the facility did not thoroughly investigate and/or document their investigation in regard to the doctor's allegation. LPN #1 indicated she went to the group home and checked the medication pods and all pills had been administered as ordered. The QMRP-D indicated she told facility staff to monitor client B to ensure the client received/swallowed his medications. The QMRP-D indicated client B did not have a problem with taking his medications nor did the client spit out his medications. The QMRP-D indicated client B's IDT did not formally meet to address client B's recommendation to ensure the client received his needed seizure medications. LPN #1 indicated she was not aware she needed to have a protocol/risk plan in place for the Diastat. Administrative staff #1 indicated she thought a protocol was written on the MAR. LPN #1 and administrative staff #1 were not able to locate the Diastat protocol on client B's MAR. LPN #1 and administrative staff #1 indicated facility staff should administer client B's Diastat when his seizures were 5 minutes or longer and call 911. Administrative staff #1 indicated</p>						

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	<p>staff #2 and #3 were terminated for neglect due to the medication administration errors which resulted in harm to clients A and B as the facility staff did not follow the facility's medication administration policy and/or report the errors timely. When asked why the staff did not report the medication error on 2/17/12, administrative staff #1 stated "Main reason they could not determine whose medications they gave to [client A]." LPN #1 indicated facility staff did not contact her in regard to the medication error. LPN #1 indicated facility staff should fill out a seizure record at the time of and/or after the seizure occurred. LPN #1 indicated facility staff did not fill out the seizure record for client B's seizure on 2/19/12 as 911 was called and the vital signs were done by the emergency medical technicians. Administrative staff #1 indicated the facility staff did not report the medication errors until 2/19/12 after client A had been hospitalized. Administrative staff #1 and LPN #1 indicated client A received her 9 PM medications and client B's 9 PM medications on 2/17/12. Administrative staff #1 indicated the hospital told her (administrative staff #1) client A's hospitalization was due to the over medication the client received. Administrative staff #1, #2 and LPN #1</p>						

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	<p>indicated client A wore oxygen at night due to the client's low oxygen saturation levels. The QMRP-D and administrative staff #2 indicated client A had not had a seizure at the group home and had not had a seizure since she was a child.</p> <p>Administrative staff #1, #2 and the QMRP-D indicated facility staff had been retrained in medication administration, Diastat use, the 6 rights of medication, abuse/neglect and when to report on 2/20/12. Administrative staff #1 indicated the facility was in the process of reviewing a new medication administration system the hospitals used to prevent/decrease medication errors.</p> <p>Administrative staff #1 indicated the facility started looking at this system after the 2/17/12 medication error.</p> <p>Administrative staff #1 and the LPN #1 indicated the QMRP-D, manager and nurse were monitoring medication passes at the group homes due to the medication errors the agency was experiencing.</p> <p>Administrative staff #1 indicated the majority of the medication errors were being made by facility staff who had worked for the company for awhile.</p> <p>Administrative staff #1 indicated the facility was retraining all long term employees on medication administration.</p> <p>LPN #1 and administrative staff #1 stated the "buddy system" was implemented after the 2/17/12 errors occurred.</p>			

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	<p>The facility's policy and procedures were reviewed on 3/7/12 at 10:58 AM and at 1:58 PM. The facility's 1/1/12 policy and procedure entitled Consumer Medications indicated "...Medication administration is one of the most important services provided to the consumer...." The policy indicated the facility staff were to follow the Core A and B curriculum (state mandated medication administration training) to ensure clients received their medications as ordered without errors. The facility's 1/1/12 policy also indicated "...If a medication error occurs, the staff person responsible for committing the error or the staff who finds error is responsible for contacting the nurse immediately. Nursing personnel will give direction based upon the individual need of the consumer with the goal of reducing and eliminating harmful side effects. The nurse will contact the doctor for further instructions on what actions to take if needed. This will protect the consumer from harmful side effects...."</p> <p>The facility's 12/1/11 policy entitled Neglect, Abuse, Battery, Exploitation Policy And Incident Reporting/Investigatory Procedure indicated "Neglect means failure to provide goods and services necessary to avoid physical or psychological harm. It</p>						

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	<p>is a situation that creates danger to an individual's physical or mental health because the caregiver is unable or fails to provide necessary support such as food, shelter, clothing, medical care, protection/safety, ...." The 12/1/11 policy indicated failure to follow medical recommendations and policies which included not informing medical personnel of medication errors and/or failure to administer required medications were considered to be abuse.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>9-3-2(a)</p>				

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 2 of 15 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to ensure facility staff reported significant medication errors to the administrator immediately for clients A and B.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/7/12 at 11:09 AM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-2/17/12 at 9:20 PM, "On 02-19-12 at approximately 8:11 a.m., [staff #3] (staff) reported that she was asked on 02-17-12 at approximately 9 p.m. to give medications to [client A] after another staff (staff #2) had prepared the medications. She reported that she gave two separate doses to [client A] after being asked to do so. She thinks [client A] may have gotten someone else's medications one of those times...."</p>	W0153	<p>Plan of Correction: All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator.</p> <p>Preventive Action: All direct care staff will be retrained on medication administration and how medication errors can be considered neglect. All direct care staff, the Assistant Manager and the Manager will be retrained on the Abuse/Neglect policy and reporting allegations of abuse/neglect immediately to the Designated Administrator. The Director of Residential Services and/or the Director of Health Services will retrain the Manager and Coordinator. The Manager and/or Coordinator will retrain the Assistant Manager and direct care staff.</p> <p>Monitoring: The Manager and/or</p>	04/11/2012			

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	<p>-2/17/12 at 9:00 PM, "It was reported on 02-19-12 that [client B] did not receive his 8 p.m. and 9 p.m. meds on 2-17-12. These medications include: Gabitril (seizure) 16mg (milligrams), Trazodone (behavior) 100mg, Certavite-Antioxidant (supplement), Castor Oil (constipation) 10cc (cubic centimeters) and Divalproex Sodium ER (Extended Release) (seizure) 500mg (2 tablets)...."</p> <p>-2/18/12 at 11:30 AM, "...[Client A] was taken by ambulance to the Emergency Room (ER) at [name of hospital] in [name of city], IN (Indiana). She was sent to the ER because she was not responsive to staff. She was awake, but did not respond when people spoke to her. Her pulse rate was 44. [Client A] was transported from [name of hospital] to [name of another hospital] IN (sic) [name of another city], IN on 2-18-12. She was taken by ambulance and admitted to [name of hospital]...."</p> <p>The facility's 2/20/12 follow-up report indicated "The allegations of neglect were substantiated because [staff #3] and [staff #2] caused [client A's] medication errors by not following KCARC's Medication Policy. The hospital concluded that she was hospitalized on 2-18-12 because of the errors on 2-17-12. Also [staff #3] and</p>		<p>Assistant Manager will be in the home when consumers are present at least 5 days per week. During this time, the Manager and/or Assistant Manager will frequently remind staff of reporting procedures for abuse/neglect. "KCARC Procedures for Reportable Incidents" will be placed in the home in a location where staff can easily access it. A nurse, Manager, Assistant Manager or Medical Assistant will monitor at least one medication pass per week. The Director of Residential Services and the Director of Health Services will monitor that all above mentioned tasks/requirements are implemented by the required due date.</p> <p>Date to be Completed By: April 11, 2012 Responsible Party: Director of Residential Services, Director of Health Services</p>				

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	<p>[staff #2] failed to report the medication errors immediately...."</p> <p>-2/19/12 at 4:00 PM, "...[Client B] had a seizure that lasted more than 5 minutes...The ambulance was called because the seizure was atypical..."</p> <p>The facility's 2/20/12 follow-up report indicated "...It is logical to conclude that [client B] had a seizure on the 19th because he missed his seizure medication on the 17th...." The 2/20/12 follow-up report indicated staff #2 and #3 failed to report the medication errors immediately.</p> <p>The facility's 2/20/12 Investigation Summaries, for the 2/17/12 to 2/19/12 incidents, indicated client A and B's trips to the ER and/or hospitalization were due to the 2/17/12 medication errors at the 9 PM medication pass. The facility's investigation summary indicated "...The medication errors were not reported until after [client A] was already in the hospital... No staff besides [staff #3] and [staff #2] were aware of the errors until [staff #3] reported them on the morning of 2-19-12...."</p> <p>Interview with administrative staff #1, administrative staff #2, LPN #1 and the Qualified Mental Retardation Professional-Designee (QMRP-D) on</p>						

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	<p>3/8/12 at 11:44 AM indicated client A went to the hospital on 2/18/12 and client B was sent out to the ER on 2/19/12 for a seizure which lasted over 5 minutes. Administrative staff #1 and LPN #1 indicated client A received her 9 PM medications and client B's 9 PM medications on 2/17/12. Administrative staff #1 indicated the hospital told her (administrative staff #1) client A's hospitalization was due to the over medication the client received. Administrative staff #1 indicated staff #2 and #3 were terminated for neglect due to the medication administration errors which resulted in harm to clients A and B as the facility staff did not follow the facility's medication administration policy and/or report the errors timely. When asked why the staff did not report the medication errors on 2/17/12, administrative staff #1 stated "Main reason they could not determine whose medications they gave to [client A]." LPN #1 indicated facility staff did not contact her in regard to the medication error. Administrative staff #1 indicated the facility staff did not report the medication errors until 2/19/12 after client A had been hospitalized.</p> <p>This federal tag relates to complaint #IN00104180.</p>						

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 15 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to an allegation of neglect which was made during the investigation of a significant medication error for client B.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/7/12 at 11:09 AM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-2/17/12 at 9:00 PM, "It was reported on 02-19-12 that [client B] did not receive his 8 p.m. and 9 p.m. meds on 2-17-12. These medications include: Gabitril (seizure) 16mg (milligrams), Trazodone (behavior) 100mg, Certavite-Antioxidant (supplement), Castor Oil (constipation) 10cc (cubic centimeters) and Divalproex Sodium ER (Extended Release) (seizure) 500mg (2 tablets). [Client B] has experienced no known harmful reastions (sic)/effects from missing these medications. Staff was suspended</p>	W0154	<p>W154</p> <p>Plan of Correction: A thorough investigation will be completed on the incident involving an allegation of neglect on Client B.</p> <p>Preventive Action: All members of the Investigation Team will be retrained by the Vice President of Program Services investigating all allegations of abuse/neglect. The Administrative Assistant will be retrained by the Director of Residential Services to monitor the thorough completion of all abuse/neglect investigation.</p> <p>Monitoring: The Administrative Assistant will monitor that all abuse/neglect allegations are thoroughly investigated.</p> <p>Date to Be Completed By: April 11, 2012 Responsible Party: Vice President of Program Services, Director of Residential Services</p>	04/11/2012			

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	<p>pending the outcome of an investigation. An investigation began immediately. Other staff were advised to report any concerns to the nurse immediately."</p> <p>-2/19/12 at 4:00 PM, "...[Client B] had a seizure that lasted more than 5 minutes. He had an order of Diastat (medication used to stop seizures), but it was not used because the ambulance had already been called. The ambulance was called because the seizure was atypical. The staff will be trained on the administration of Diastat."</p> <p>The facility's 2/20/12 follow-up report indicated "...It is logical to conclude that [client B] had a seizure on the 19th because he missed his seizure medication on the 17th..." The 2/20/12 follow-up report indicated staff #2 and #3 neglected to follow the facility's policy and procedures in regard to medication administration and failed to report the medication errors immediately.</p> <p>The facility's 2/20/12 Investigation Summaries, for the 2/17/12 to 2/19/12 incidents, indicated client B's trip to the ER was due to the 2/17/12 medication error at the 9 PM medication pass.</p> <p>Staff #2's 2/19/12 facility's witness statement and/or the 2/19/12 County</p>						

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	<p>Sheriff Department Voluntary Statement indicated "At 8:30 I began Med Pass-I remember [client D] was first in getting her meds- It was kind of a wild night. I remember [staff #3] asking me if I had given [client A's] meds twice and if everyone had been given their meds And (sic) I thought I Remembered (sic) giving everyone their Meds- We looked through the MARS (Medication Administration Records) and it all seemed ok. I remember giving [client B] his meds but it must have been 5:00. I remember I gave 5:00 Meds Also (sic). I (staff #2) asked (staff #3) to carry meds-cause my feet were hurting so bad I could hardly stand let alone walk back of the house (sic)."</p> <p>Client B's record was reviewed on 3/7/12 at 1:24 PM. Client B's 2/19/12 Emergency Room Note indicated client B was seen in the ER due to seizures. The 2/19/12 ER note indicated labs were conducted in regard to client B's seizure medications. The 2/19/12 note indicated "Carbamazepine (seizure) level was less than 0.1 Valporic acid (seizure) level was less than 0.1. According to the group home record, he is taking his medication...According to group home record, he is getting this medicine but according to his labs it does not look like he is actually ingesting this...Impression:</p>						

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	<p>Breakthrough seizure, exact etiology unclear, it appears that he is not getting this medication." Client B's 2/19/12 labs indicated client B's Tegretol (Carbamazepine) level was "L" (low) &lt; (less than) 2.0 with a normal range being 8.0 to 12.0. Client B's 2/19/12 lab for Depakene (Valporic Acid/Divalproex) was "L" &lt; 10.0 with a normal range being 50.0 to 100.0.</p> <p>Client B's 2/12 physician's order indicated client B's diagnosis included, but was not limited to, Major Epilepsy. Client B's 2/20/12 faxed note to client B's doctor at 12:55 PM indicated the facility's nurse was faxing the client's doctor to obtain an order for labs "...due to recent seizure activity." The 2/20/12 faxed note indicated client B's doctor documented "Is he the one that was seen in ER-They did not show he was taking his meds. What are his seizure meds. They need to be ordered specifically. Make sure he takes his meds." A second 2/20/12 faxed note from the client's nurse to client B's doctor at 4:42 PM, indicated client B "Missed all evening doses on 2/17/12 &amp; had a seizure on 2/19 @ (at) around 3 pm. He received all meds between that time." Client B's doctor's response at the bottom of the faxed note indicated "Give meds as Directed &amp; wait 2 weeks-Then do Depakote; Tegretol &amp; Keppra</p>						

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	<p>level...Make sure he is swallowing meds &amp; not spitting out later. ER told me his levels were '0'."</p> <p>Client B's 2/12 monthly nursing note indicated the following (not all inclusive):</p> <p>-2/19/12 "Consumer sent to er for seizure activity. Labs drawn and levels appeared to be low. Seizure stopped and consumer sent home. Appts (appointments) made with pcp (primary care physician) and neuro (neurologist)."</p> <p>2/21/12 "Spoke with [name of neurologist] office about lab work done at er. New labs ordered for cbc,chem14,serum, tegretol,depakene,gabitril, and keppra (all seizure meds) (sic)." The 2/21/12 nurse note failed to include any additional documentation/conversation with the neurologist.</p> <p>The facility's 2/20/12 Investigation Summary failed to address and/or include additional information/investigation and/or documentation in regard to the allegation of client B not receiving his seizure medications due to the low levels of client B's seizure medications.</p> <p>Interview with administrative staff #1, administrative staff #2, LPN #1 and the</p>						

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	<p>Qualified Mental Retardation Professional-Designee (QMRP-D) on 3/8/12 at 11:44 AM indicated client B was sent out to the ER on 2/19/12 for a seizure which lasted over 5 minutes. Administrative staff #2 stated client B's seizure on 2/19/12 was not his "typical seizure." LPN #1 indicated client B's neurologist stated client B's low Tegretol and Depakote levels were "probably a lab mix-up." LPN #1 indicated client B's primary care doctor was concerned about the client's low levels and was concerned client B was not getting his medication. LPN #1 indicated she did not document what the neurologist said to her. LPN #1 indicated she went to the group home and checked the medication pods and all pills had been administered as ordered. The QMRP-D indicated she told facility staff to monitor client B to ensure the client received/swallowed his medications. The QMRP-D indicated client B did not have a problem with taking his medications nor did the client spit out his medications. Administrative staff #1 and #2 indicated the facility did not thoroughly investigate and/or document their investigation in regard to the doctor's allegation.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>9-3-2(a)</p>						

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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 interview and record review for 1 of 4 sampled clients (B), the facility's nursing services failed to put in place a nursing protocol/risk plan for the use of Diastat to ensure facility staff knew when and/or how to use the as needed medication to stop seizures. The facility's nursing services failed to ensure pertinent communication with doctors was documented, and/or failed to ensure facility staff completed seizure records when needed.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/7/12 at 11:09 AM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-2/17/12 at 9:00 PM, "It was reported on 02-19-12 that [client B] did not receive his 8 p.m. and 9 p.m. meds on 2-17-12. These medications include: Gabitril (seizure) 16mg (milligrams), Trazodone (behavior) 100mg, Certavite-Antioxidant (supplement), Castor Oil (constipation) 10cc (cubic centimeters) and Divalproex Sodium ER (Extended Release) (seizure)</p>	W0331	<p>W331</p> <p>Plan of Correction: A nursing protocol/risk plan will be developed for the use of Diastat for Client B to ensure staff knows when and how to use the as needed medication for seizures. Nursing staff will be retrained by the Director of Health Services to review/revise risk plans when appropriate, to ensure pertinent communication with physicians is documented, and to monitor the correct completion and timely of seizure records. All direct care staff will be trained by the Nurse on Client B's protocol for the use of Diastat and on completing seizure records timely and accurately.</p> <p>Preventive Action: Nursing staff will be retrained by the Director of Health Services to review/revise risk plans when appropriate, to ensure pertinent communication with physicians is documented, and to monitor the correct completion and timely of seizure records. All direct care staff will be trained by the Nurse on Client B's protocol for the use of Diastat and on completing seizure records timely and accurately.</p> <p>Monitoring: An Assistant Manager or Manager will be in the</p>	04/11/2012			

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	<p>500mg (2 tablets). [Client B] has experienced no known harmful reastions (sic)/effects from missing these medications...Other staff were advised to report any concerns to the nurse immediately."</p> <p>-2/19/12 at 4:00 PM, "...[Client B] had a seizure that lasted more than 5 minutes. He had an order of Diastat (medication used to stop seizures), but it was not used because the ambulance had already been called. The ambulance was called because the seizure was atypical. The staff will be trained on the administration of Diastat."</p> <p>The facility's 2/20/12 follow-up report indicated "...It is logical to conclude that [client B] had a seizure on the 19th because he missed his seizure medication on the 17th...." The facility's 2/20/12 Investigation Summaries, for the 2/17/12 to 2/19/12 incidents, indicated client B's trip to the ER was due to the 2/17/12 medication error at the 9 PM medication pass. The facility's investigation summaries indicated "...Because the ambulance arrived prior to the seizure lasting five minutes, Diastat was not administered (for client B)...."</p> <p>Client B's record was reviewed on 3/7/12 at 1:24 PM. Client B's 2/19/12</p>		<p>home at least five days per week to ensure retraining has been implemented. The Nurse will monitor that seizure records are filled out correctly and timely. The Director of Health Services and Director of Residential Services will monitor to ensure all of the changes mentioned above are implemented by the due date.</p> <p>Date to Be Completed by: April 11, 2012 Responsible Party: Director of Health Services, Director of Residential Services</p>				

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	<p>Emergency Room Note indicated client B was seen in the ER due to seizures. The 2/19/12 ER note indicated labs were conducted in regard to client B's seizure medications. The 2/19/12 note indicated "Carbamazepine (seizure) level was less than 0.1 Valporic acid (seizure) level was less than 0.1. According to the group home record, he is taking his medication...According to group home record, he is getting this medicine but according to his labs it does not look like he is actually ingesting this...Impression: Breakthrough seizure, exact etiology unclear, it appears that he is not getting this medication." Client B's 2/19/12 labs indicated client B's Tegretol (Carbamazepine) level was "L" (low) &lt; (less than) 2.0 with a normal range being 8.0 to 12.0. Client B's 2/19/12 lab for Depakene (Valporic Acid/Divalproex) was "L" &lt; 10.0 with a normal range being 50.0 to 100.0.</p> <p>Client B's 2/12 physician's order indicated client B's diagnosis included, but was not limited to, Major Epilepsy. Client B's 2/20/12 faxed note to client B's doctor at 12:55 PM indicated the facility's nurse was faxing the client's doctor to obtain an order for labs "...due to recent seizure activity." The 2/20/12 faxed note indicated client B's doctor documented "Is he the one that was seen in ER-They did</p>			

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	<p>not show he was taking his meds. What are his seizure meds. They need to be ordered specifically. Make sure he takes his meds." A second 2/20/12 faxed note from the client's nurse to client B's doctor at 4:42 PM, indicated client B "Missed all evening doses on 2/17/12 &amp; had a seizure on 2/19 @ (at) around 3 pm. He received all meds between that time." Client B's doctor's response at the bottom of the faxed note indicated "Give meds as Directed &amp; wait 2 weeks-Then do Depakote; Tegretol &amp; Keppra level...Make sure he is swallowing meds &amp; not spitting out later. ER told me his levels were '0'."</p> <p>Client B's 2/12 monthly nursing note indicated the following (not all inclusive):</p> <p>-2/19/12 "Consumer sent to er for seizure activity. Labs drawn and levels appeared to be low. Seizure stopped and consumer sent home. Appts (appointments) made with pcp (primary care physician) and neuro (neurologist)."</p> <p>2/21/12 "Spoke with [name of neurologist] office about lab work done at er. New labs ordered for cbc,chem14,serum, tegretol,depakene,gabitril, and keppra (all seizure meds) (sic)." The 2/21/12 nurse note did not indicate/include any</p>						

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	<p>additional documentation/conversation with the neurologist in regard to the client's low levels.</p> <p>Client B's record, 7/29/11 Individual Support Plan and/or 8/1/11 Risk Plan did not indicate client B's interdisciplinary team (IDT) and/or nursing services met to discuss and/or address client B's doctor's concerns and/or recommendation in regard to ensuring the client received his medications.</p> <p>Client B's 12/2/11 Seizure Description Record indicated client B's last documented seizure was on 12/2/11. The 12/2/11 seizure record indicated "He had a petit mal seizure. His mouth would draw in when he breathed and his hands were drawn in...." Client B's record indicated the facility did not document client B's 2/19/12 seizure which resulted in a trip to the ER.</p> <p>Client B's 1/5/12 physician's order indicated client B received "Diastat Accudial 5-7.5 to 10 mg rectally PRN (as needed) for seizures." Client B's 8/1/11 Risk Issues indicated client B had a nursing protocol/risk plan for seizures. The 8/1/11 risk plan indicated the following (not all inclusive):</p> <p>"1. Continue medications as prescribed</p>						

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	<p>by physician. 2. Follow Seizure Protocol Plan in place. 3. Nurse will monitor labs as ordered by physician and report abnormal values to physician...5. Report any seizure activity to nurse and complete Seizure Description form...." Client B's 8/1/11 seizure risk plan did not include and/or indicate a risk plan for the use of the PRN Diastat.</p> <p>The facility's inservice training records were reviewed on 3/8/12 at 2:20 PM. The facility's 11/14/11 Employee Training Record indicated facility staff were trained on Diastat Administration on 11/14/11.</p> <p>Interview with staff #1 on 3/6/12 at 9:10 PM indicated facility staff were not to pre-set up medications and/or administer medications and have other staff pass the medications.</p> <p>Interview with administrative staff #1, administrative staff #2, LPN #1 and the Qualified Mental Retardation Professional-Designee (QMRP-D) on 3/8/12 at 11:44 AM indicated client B was sent out to the ER on 2/19/12 for a seizure which lasted over 5 minutes. QMRP-D indicated Diastat was not used as 911 was called. Administrative staff #2 stated client B's seizure on 2/19/12 was not his "typical seizure." LPN #1</p>						

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	<p>indicated client B's neurologist stated client B's low Tegretol and Depakote levels were "probably a lab mix-up." LPN #1 indicated client B's primary care doctor was concerned about the client's low levels and was concerned client B was not getting his medication. LPN #1 indicated she did not document what the neurologist said to her. LPN #1 indicated she went to the group home and checked the medication pods and all pills had been administered as ordered. The QMRP-D indicated she told facility staff to monitor client B to ensure the client received/swallowed his medications. The QMRP-D indicated client B did not have a problem with taking his medications nor did the client spit out his medications. The QMRP-D indicated client B's IDT did not formally meet to address client B's recommendation to ensure the client received his needed seizure medications. LPN #1 indicated she was not aware she needed to have a protocol/risk plan in place for the Diastat. Administrative staff #1 indicated she thought a protocol was written on the MAR. LPN #1 and administrative staff #1 were not able to locate the Diastat protocol on client B's MAR. LPN #1 and administrative staff #1 indicated facility staff should administer client B's Diastat when his seizures were 5 minutes or longer and call 911. Administrative staff #1 indicated</p>						

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	<p>staff #2 and #3 were terminated for neglect due to the medication administration errors which resulted in harm to clients A and B as the facility staff did not follow the facility's medication administration policy. When asked why the staff did not report the medication error on 2/17/12, administrative staff #1 stated "Main reason they could not determine whose medications they gave to [client A]." LPN #1 indicated facility staff did not contact her in regard to the medication error. LPN #1 indicated facility staff should fill out a seizure record at the time of and/or after the seizure occurred. LPN #1 indicated facility staff did not fill out the seizure record for client B's seizure on 2/19/12 as 911 was called and the vital signs were done by the emergency medical technicians.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>9-3-6(a)</p>				