

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G752	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/13/2012
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9104 STRATHMORE LN FORT WAYNE, IN 46818
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: July 9, 10, 11, 12 and 13, 2012.</p> <p>Facility number: 011871 Provider number: 15G752 AIM number: 200921870</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/19/12 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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W0148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &amp;</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview, the facility failed to notify the guardian of a change in dosage of psychotropic medication for 1 of 2 sampled clients who took psychotropic medications (client #1).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/12/12 at 12:21 P.M.. Client #1's psychotropic medication review form dated 5/2/12 indicated the psychiatrist had ordered an increase in Risperdal (anti-psychotic) from 3.5 mg (milligrams) at HS (hour of sleep) to 4.0 mg at HS. Client #1's record did not indicate the guardian had been notified of the increase.</p> <p>Client #1's guardian was interviewed by phone on 7/10/12 at 10:53 A.M.. Client #1's guardian indicated she was pleased with the services client #1 is receiving. The guardian stated, "I used to be able to go to all of her appointments, but am not able to do it now. I don't know what her</p>	W0148	<p><u>W148</u></p> <p>For Client #1, QIDP informed guardian on 7/27/12 that client had a documented failed reduction of medication and client is back on original dose of medication. QIDP will send out Program Approval Form to guardian to sign indicating the increase back to original dose of medication.</p> <p>- Person Responsible: QIDP Completion Date: 7/27/12</p> <p>To ensure compliance, Agency RN will send to guardians/Health Care Reps an Informed Consent for Medication when psychotropic medications are increased for guardian to sign. When guardian does attend Medication Reviews with psychiatrist, QIDP will have guardian sign the Psychotropic Medication Form agreeing to the medication change. QIDP and agency nurses will be re-inserviced.</p> <p>- Person Responsible: QIDP; Agency RN Completion Date: 8/12/12</p>	08/12/2012			

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	<p>psych (psychotropic) medications are now; they discussed a possible decrease, but I never heard what happened afterwards. I would like to know what happens at her appointments, and about any recommendations her doctors make."</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 7/13/12 at 11:15 A.M. When asked if the guardian was notified of the Risperdal increase, the QDDP stated, "It was a failed attempt at a decrease. She had been taking 4.0 mg at bedtime; it was decreased in February down to 3.5 mg. I believe I called the guardian, but I do not believe I can locate any documentation to prove it."</p> <p>9-3-4(a)</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.</p> <p>Based on record review and interview, the facility failed to follow the Abuse and Neglect policy by staff sending a client to their bedroom for the rest of the evening instead of following the Behavior Support Plan (BSP) for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>The facility records were reviewed on 7/11/12 at 11:25 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 1/10/12 for an incident on 1/7/12 at 8:00 P.M. indicated "...she (client #1) reported to her guardian and to group home staff that over the weekend she had left a message on her guardian's telephone stating 'isn't it terrible what that man did to that little girl?' after having seen a recent news story of a recent murder of a young girl in [name of city]. Reportedly, when [client #1] hung up the phone, she was laughing. The staff person working that night, [direct care staff #5], informed [client #1]</p>	W0149	<p><u>W149</u> For Client #1 DSP #5 was given proper disciplinary action on 1/26/12.</p> <p>Person Responsible: QIDP; Residential Supervisor Completion Date: 1/26/12</p> <p>To ensure compliance all staff at group home will be in-serviced that it is considered abuse/neglect/exploitation when a staff makes a client go to their room as punishment. Also staff will be in-serviced on following agency policy when abuse/neglect/exploitation is known.</p> <p>- Person Responsible: QIDP; Residential Supervisor Completion Date: 8/12/12</p>	08/12/2012			

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	<p>that she shouldn't be laughing at something like that and instructed her 'to go to her room and stay there the rest of the night.' According to [client #1], she stayed in her room the rest of the night. This statement is being considered an allegation of abuse."</p> <p>A follow-up BDDS report dated 1/16/12 for the incident on 1/7/12 indicated "An investigation into this incident revealed that the staff person involved [DCS #5], did document that she told [client #1] to go into her bedroom if she wished to laugh about the earlier reported subject. The allegation of abuse was deemed substantiated as telling [client #1] 'to go to her room' was not an acceptable form of staff behavioral intervention, per [client #1's] BSP which outlines the importance of staff to give [client #1] options and not demands when malaptive (sic) redirection is needed."</p> <p>The facility Standard Operating Procedures / Abuse and Neglect Policy revision date 5/07 was reviewed on 7/9/12 at 3:57 P.M.. The policy indicated "A.)...Abuse, neglect, exploitation, and mistreatment are expressly forbidden...Suspected instances of neglect, abuse, exploitation, client mistreatment or any infractions of this policy by staff must be reported to the</p>			

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	<p>Supervisor, Manager, or President immediately. This supervisor will then report the alleged violation(s) to the client's legal representative if applicable and to any other person according to BDDS regulations when applicable. Employees must report suspected or observed instances of neglect, abuse, or exploitation...."</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 7/13/12 at 11:15 A.M.. When asked about the incident with client #1 and DCS #5, the QDDP stated, "It is never in a client's BSP to go to their room as punishment. She (DCS #5) did not follow her (client #1's) BSP, and the agency policy is to follow the plan." The QDDP indicated the staff had not followed the facility policy regarding abuse and neglect.</p> <p>9-3-2(a)</p>						

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview, the facility failed to address an oral hygiene need as identified by the dentist for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/12/12 at 12:21 P.M.. Client #1's dental appointment form dated 3/15/12 indicated "gingivitis, Please make sure [client #1] is brushing gum line better but gently." Client #1's Individual Support Plan (ISP) dated 11/28/11 did not include a tooth brushing or oral hygiene goal.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 7/13/12 at 11:15 A.M.. When asked about the dental recommendations for client #1, the QDDP indicated he thought client #1 had a tooth brushing goal.</p> <p>9-3-4(a)</p>	W0227	<p><u>W227</u> For Client #1 QIDP has implemented a tooth brushing goal for client to brush along gum line. An addendum to the ISP for tooth brushing was added 7-27-12. Staff will be in-serviced on this new goal. Person Responsible: QIDP Completion Date: 8/12/12 To ensure compliance Observations will be conducted by the Residential Supervisor twice per month and the QIDP once per month. Observers will look to ensure ISP and goals are in the ISP that is needed. Also, after clients have a dental appointment, Agency RN will forward the dental exam form to QIDP to make sure dental recommendations are followed through with goals written. Person Responsible: QIDP; Agency RN Completion Date: 8/12/12</p>	08/12/2012	

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility staff sent a client to her bedroom for the rest of the evening instead of following the individualized Behavior Support Plan (BSP) for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>The facility records were reviewed on 7/11/12 at 11:25 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 1/10/12 for an incident on 1/7/12 at 8:00 P.M. indicated "...she (client #1) reported to her guardian and to group home staff that over the weekend she had left a message on her guardian's telephone stating 'isn't it terrible what that man did to that little girl?' after having seen a recent news story of a recent murder of a young girl in [name of city]. Reportedly, when [client</p>	W0249	<p><u>W249</u></p> <p>For client #1, Residential Supervisor will in-service staff on the client's Behavior Support Plan.</p> <p>Person Responsible: Residential Supervisor; QIDP Completion Date: 8/12/12</p> <p>To ensure compliance for all clients, annually, after each clients ISP staff will be trained on the new ISP that includes ISP goals. If new staff/temps come in, they will be instructed to read the house information book before their shift. Observations will be conducted by the Residential Supervisor twice per month and the QIDP once per month. Observers will look to ensure staff is implementing Behavior Support Plans as written.</p> <p>Person Responsible: Residential Supervisor; QIDP Completion Date: 8/12/12</p>	08/12/2012			

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	<p>#1] hung up the phone, she was laughing. The staff person working that night, [direct care staff #5], informed [client #1] that she shouldn't be laughing at something like that and instructed her 'to go to her room and stay there the rest of the night.' According to [client #1], she stayed in her room the rest of the night. This statement is being considered an allegation of abuse."</p> <p>A follow-up BDDS report dated 1/16/12 for the incident on 1/7/12 indicated "An investigation into this incident revealed that the staff person involved [DCS #5], did document that she told [client #1] to go into her bedroom if she wished to laugh about the earlier reported subject. The allegation of abuse was deemed substantiated as telling [client #1] 'to go to her room' was not an acceptable form of staff behavioral intervention, per [client #1's] BSP which outlines the importance of staff to give [client #1] options and not demands when malaptive (sic) redirection is needed."</p> <p>Client #1's record was reviewed on 7/12/12 at 12:21 P.M.. Client #1's record indicated she had a BSP dated 11/28/11. Client #1's BSP indicated the following interventions (not all inclusive): "A. Focus on prevention...building on positive adaptive behaviors, increasing positive</p>				

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	<p>communication skills, increasing appropriate social skills and ability to problem solve. B. Build a positive Relationship...mutual respect, dignity, choices, 'being an adult', 'lady like' are key words. C. Consistency...staff consistency with expectations, reinforcement chart, self-regulation. D. Attention from others, role modeling, conversations, ask her what she thinks, choices, use humor, explain/educate." Client #1's BSP did not include having her go to her room for any reason.</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 7/13/12 at 11:15 A.M.. When asked about the incident with client #1 and DCS #5, the QDDP stated, "It is never in a client's BSP to go to their room as punishment. She (DCS #5) did not follow her (client #1's) BSP, and the agency policy is to follow the plan."</p> <p>9-3-4(a)</p>			

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W0322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed to obtain a timely yearly physical for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/12/12 at 1:45 P.M.. Client #2's record indicated she had an annual physical on 6/10/10, and a wellness visit with her Primary Care Physician (PCP) on 9/15/11. Client #2's record indicated her mother served as her Health Care Representative (HCR).</p> <p>The facility RN was interviewed on 7/12/12 at 3:50 P.M.. When asked about client #2's annual physical the RN stated, "Her mom schedules and takes her to all of her appointments." The RN indicated she understood the physical was not timely.</p> <p>9-3-6(a)</p>	W0322	<p><u>W322</u></p> <p>For Client #2 mother did schedule a physical for 9/2012. Mother was informed from last year that mother needed to schedule the annual physical in a timely manner. Mother took the wrong paperwork to the appointment last year, but Client #2 did have appointment for last year on 9/15/11. Agency nurse did fax the correct paperwork to the doctor's office to complete 7/26/12.</p> <p>Person Responsible: QIDP; Agency RN Completion Date: 8/12/12</p> <p>To ensure compliance, agency RN will communicate with family that prefer to take their loved one to appointments themselves. Agency RN will send the proper paperwork to the family for stress the importance of having the forms filled out correctly from the physician and family. Family will bring back the paperwork to the RN after the appointment. Agency RN will document communications with family concerning client appointments family members take clients to. Agency nurse will be responsible to follow up with families to ensure correct paperwork is received.</p>	08/12/2012	

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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 obtain clarification of a Physician's Order (PO) for 1 of 3 sampled clients (client #2) in accordance with client #2's current health needs.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 7/12/12 at 1:45 P.M.. Client #2's PO signed and dated by her Primary Care Physician (PCP) on 6/14/2012 indicated client #2 was to "Avoid These Things: 1). Sitting with legs bent underneath her. 2). Sitting with Legs Crossed. 3). Sitting in Chair w/ (with) feet not supported by footstool. * For Left Thigh Muscle Strain."</p> <p>Observations were conducted at the group home on 7/9/12 from 5:03 P.M. through 7:08 P.M.. Client #2 was sitting in a variety of positions. Client #2 was not observed to use a foot stool. Client #2 was not observed to be offered a footstool or be redirected if she bent or crossed her legs.</p> <p>Observations were conducted at the group</p>	W0331	<p><u>W331</u> For client #2; this was an old order for a left thigh muscle strain a couple of years ago and never taken off of the Physician's orders. The physician has already stated these orders are no longer needed. The orders have been discontinued as of 7/24/12.</p> <p>Person Responsible: Agency RN Completion Date: 7/24/12</p> <p>To ensure compliance the agency RN will review physician's orders for accuracy before sending them to the physician to sign. Nursing Supervisor to provide oversight by randomly auditing client nursing files every quarter.</p> <p>Person Responsible: Agency nursing supervisor Completion Date: 8/12/12</p>	08/12/2012			

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	<p>home on 7/10/12 from 6:13 A.M. through 7:38 A.M.. Client #2 was once again sitting in a variety of positions. Client #2 was not observed to use a foot stool. Client #2 was not observed to be offered a footstool or be redirected if she bent or crossed her legs.</p> <p>The facility RN was interviewed on 7/12/12 at 3:50 P.M.. When asked about the list of things on client #2's PO which she is to avoid doing, the RN stated, "I am very new at this facility, but the PO does indicate [client #2] is to not cross her legs, bend them underneath her and is to use a footstool."</p> <p>The Qualified Developmental Disabilities Professional (QDDP) was interviewed on 7/13/12 at 11:15 A.M.. When asked about the things client #2 was to avoid, the QDDP stated, "I think that was for a muscle strain as a temporary order from a couple of years ago. She (client #2) does not have any current corresponding diagnosis to go along with why she should need to continue to avoid doing those things." The QDDP indicated it should not still be part of the PO for client #2.</p> <p>9-3-6(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 9104 STRATHMORE LN FORT WAYNE, IN 46818
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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 (PO) for 3 of 3 sampled clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>The facility records were reviewed on 7/11/12 at 11:25 A.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 12/5/11 for an incident on 12/4/11 at 6:00 A.M. indicated "The staff passing 6:00 A.M. medications on 12/5/11 discovered the birth control pill (for client #3), Loestrin 21 1.5-30 TABLET (sic) was still in the package for 12/4/11. The staff called the on call nurse to report the pill was not given."</p> <p>A BDDS report dated 12/7/11 for an incident on 12/7/11 at 6:00 A.M. indicated "The nurse for [client #3] was notified on 12/6/11 that [client #3] had no more Microgestin (generic for Loestrin)</p>	W0368	<p><u>W368</u></p> <p>For clients #1, #2 and #3, the agency will in-service staff on correct medication administration of medications as per physician's orders, ensure medications are available to be given, agency policies regarding missed does of medications. Each staff for which medication errors occurred was given disciplinary action per agency policy. For Client #2 agency RN will be meeting with mother to stress the importance of medications being properly administered according to physician's orders. Staff is to be checking and recording to ensure there is a 10 day supply of all medications in the home once a week.</p> <p>Agency RN's will be in-serviced on ensuring medications ordered from pharmacy are delivered in a timely manner and staff at group home will be in-serviced on checking medications that may be running low and inform RN medications need to be ordered</p> <p>Person Responsible: Residential Supervisor; QIDP; Nursing Supervisor Completion Date: 8/12/12</p> <p>To ensure compliance for all clients,</p>	08/12/2012			

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	<p>21 1.5-30 at her home. The nurse informed the pharmacy that [client #3] would need more medication by the morning of 12/7/11. The pharmacy stated they would deliver it to the group home before the medication was due on the morning of 12/7/11. [Client #3's] morning dose of Microgestin 21 1.5-30 was not delivered until after the window for her to receive her medication, therefore she missed a dose of her medication."</p> <p>A BDDS report dated 1/20/12 for an incident on 1/18/12 at 6:00 A.M. indicated "[Client #3] did not receive her 1/18/12 or 1/19/12 6:00 A.M. dose of Microgestin 21 1.5-30 tab (tablet) to regulate her hormones. At 5:30 P.M. on 1/19/12 her group home supervisor was checking the medications. She observed that the pills were still in the package for these two days. A substitute staff had been passing medications and missed this medication...."</p> <p>A BDDS report dated 1/6/12 for an incident on 12/22/12 at 6:00 A.M. indicated "[Client #3] was to start Aspirin 81 mg (milligrams) on 12/22/11 as ordered by her physician. The pharmacy sent a letter via the fax on 12/22/11 asking for the doctor to clarify if her (sic) wanted her on this medication. [Client #3's] nurse at Easter Seals ARC had not</p>		<p>Residential Supervisors are checking the EMAR twice a week to ensure medications are not being missed and are being documented properly. Staff is to be checking and recording to ensure there is a 10 day supply of all medications in the home once a week and inform RN of the supply. Observations will be conducted by the Residential Supervisor twice per month and the QIDP once per month to ensure medications are correctly given and medications are in the group home.</p> <p>Person Responsible: Residential Supervisor; QIDP; Agency RN Completion Date: 8/12/12</p>	

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	<p>instructed the staff to start the medication, but the medication was delivered to the home without the nurse's knowledge. The staff wrote the medication on the MAR (medication administration record) and administered the medication without asking the nurse if this was the correct action to take. Since the agency nurse was unaware the medication was started she did not tell staff to hold the aspirin. The physician had responded to the pharmacy, stating not to start the medication. The agency nurse had let the staff know the medication was not to be started, but it was given without the nurse's knowledge from 12/22 until 12/30. This was discovered on 1/6/12 when the agency nurse was reviewing the MAR from last month."</p> <p>A BDDS report dated 1/15/12 for an incident on 1/14/12 at 12:00 P.M. indicated "Agency nursing staff reported today that [client #2] had no Armour Thyroid 15 mg (hypothyroidism) from 1/8 until today (1/14/12). Her thyroid (sic) was increased on 1/4, and this is where the extra 15 mg dose came from. She was still receiving 90 mg everyday, but should have been receiving 105 mg. She received today's dose from her mother. Her mother was made aware on 1/6 that she needed to start supplying [client #2's] thyroid (sic) because medicaid/care would not pay for</p>			

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	<p>it, but would pay for other brands, but the mother wants her on that specific brand. She agreed to do this and brought in a new prescription to the nursing office the week of 1/9. We were under the assumption that she had been supplying the medication. [Client #2's] mother dropped off a 90 day supply today...."</p> <p>A BDDS report dated 2/15/12 for an incident on 2/9/12 indicated "[Client #1] had a recent pacemaker placement due to atrial fibrillation. When she left the hospital she had new medications that were ordered. Her family physician clarified on 2/8/12 what medications [client #1] should remain on, and which medications should be discontinued. [Client #1] was to have her Ranitidine (GERD) 150 mg daily discontinued. The nurse for [client #1] went to the home that day and wrote 'd/c' (discontinued) on the order to discontinue the medication. The medication was still in the home, and the morning staff continued to give the medication on 2/9/12 and 2/10/12. This was in error."</p> <p>A BDDS report dated 2/15/12 for an incident on 2/11/12 at 6:00 A.M. indicated " She(client #3) is prescribed a total of 100 mg of Seroquel XR (anti-psychotic) every morning. She receives this in two 50 mg tablets. The</p>			

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	<p>staff did not administer two tablets on 2/11/12 and 2/12/12. The staff only administered one of the two 50 mg tablets on both of these days."</p> <p>A BDDS report dated 3/8/12 for 2/23/12 at 6:00 A.M. indicated "It was reported to the nurse for [client #2] by a sub staff that there was a medication not in the home for [client #2]. The nursing supervisor went to the home to investigate. The medication, Calcium Malate Chelate (supplement) is provided by [client #2's] mother. Upon investigation the supplement was no longer in the home, nor was the bottle. It is unclear when the medication left the home...the staff have had confusion about [client #2's] medication order since 2/23/12, and had not reported this to the nurse. It was reported as not given on 2/23, 2/24, 2/27, 2/28, 3/2, 3/3, 3/4, 3/5, 3/6 and 3/7."</p> <p>The facility Standard Operating Procedures / Abuse and Neglect Policy revision date 5/07 was reviewed on 7/9/12 at 3:57 P.M.. The policy indicated " F.) Medications and treatments will be administered as specified by physician orders and as taught in the 'Living in the Community' Core A and Core B ... it will be a medication error if medications and/or treatments are not administered as specified by the physician's</p>			

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	<p>orders...termination will be the result for any of the following: 1. Intentionally concealing a medication error or failing to report a known medication error...."</p> <p>The facility RN was interviewed on 7/12/12 at 3:50 P.M.. When asked about the medication errors at the home, the RN stated, "I am aware of some of them. I believe they occurred due to [client #2's] mom not supplying us with the medication. She likes specific brands of medications or supplements to be given." The RN indicated she was new at her position with the facility and was not sure why all of the medication errors had occurred. The RN stated the "medications are to be given according to the PO."</p> <p>9-3-6(a)</p>			
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