

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G117		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/08/2012	
NAME OF PROVIDER OR SUPPLIER HOUSTON GROUP HOMES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 220 W MAIN ST CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey dates: June 4, 5, 6, 7 and 8, 2012.</p> <p>Facility number: 000654 Provider number: 15G117 AIMS number: 100234270</p> <p>Surveyor: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on June 14, 2012 by Dotty Walton, 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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W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all medications were administered without error for 1 of 16 medications observed for administration (client #2).</p> <p>Findings include:</p> <p>During observations on 06/04/2012 at 6:30 p.m., Direct Support Professional (DSP) #2 interrupted client #2's dinner to administer Flomax (medication used to treat enlarged prostate) 0.4 mg (milligrams) by mouth. Client #2 took the medication, then returned to the dining room and resumed eating his dinner.</p> <p>During an interview on 06/04/2012 at 6:30 p.m., DSP #2 indicated she was instructed by the Residential Trainer to administer Flomax to client #2 at 6:30 p.m. She stated, "The evening meal is normally served at 6:00 p.m."</p> <p>During an interview on 06/04/2012 at 7:00 p.m., the Residential Supervisor stated, "I am filling out a med (medication) error report (for the medication given</p>	W0369	<p>The facility Executive Director had a conversation with the Residential Supervisor on June 4, 2012. The purpose of the conversation was to discuss the plan to correct deficiency tag numbers W-369 cited during the Indiana State Department of Health annual re-certification survey completed on June 8, 2012.</p> <p>On June 4, 2012 The Director instructed the Residential Supervisor to have the staff person responsible for the medication to re-read the policy for Medication Administration as a form of immediate training. (See Attachment A). Disciplinary action was taken on 6/6/12 for company offenses, failure to administer medication according to the six rights. (See Attachment</p>	06/12/2012			

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	<p>during the meal)." He indicated the medication should have been given according to label instructions of 1/2 hour after the meal.</p> <p>During an interview on 06/04/2012 at 7:05 p.m., The Residential Trainer stated, "The MAR (Medication Administration Record) says the medication is supposed to be given at 6:30 (p.m.)." She indicated the evening meal was normally served at 6:00 p.m.</p> <p>Client #2's record was reviewed on 06/05/2012 at 10:30 a.m. The Medication Administration Record, dated 06/01/2012-06/30/2012, indicated, "...TAMSULOSIN(Flomax) 0.4 MG CAPS (capsule) TAKE 1 CAPSULE BY MOUTH ONCE DAILY 30 MINUTES AFTER THE SAME MEAL EACH DAY FOR BPH...." A hand written entry for administration time indicated 6:30 p.m. The Physician's Orders, dated 06/01/2012-06/30/2012, indicated, "...TAMSULOSIN (Flomax) 0.4 MG CAPS (capsule) TAKE 1 CAPSULE BY MOUTH ONCE DAILY 30 MINUTES AFTER THE SAME MEAL EACH DAY FOR BPH...."</p> <p>9-3-6(a)</p>		<p>B). The Director of Nursing observed a medication pass on 6/12/12. (See Attachment C.) The staff person was re-trained by listening to the Medication In-service presented by the Director of Nursing using their-service tape dated 4/10/10 on 6/12/12. (See Attachment D.) The order was written as a new order on the Medication Administration Record without a time and for the pm. (See Attachment E.) The Director of Nursing will continue to do observations on at least an annual basis. All staff are expected to pass medications with 100% accuracy.</p> <p>Completion Date: 6/12/12</p>				

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