

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G132		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/13/2013	
NAME OF PROVIDER OR SUPPLIER  BI-COUNTY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711			
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 8, 9, 10, 13, 2013.</p> <p>Facility number: 000669 Provider number: 15G132 AIM number: 100234280</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/17/13 by Ruth Shackelford, QIDP.</p>			W000000			

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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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the Program Manager (PM)/Qualified Intellectual Disabilities Professional (QIDP) failed to review and/or revise their Individual Support Plan (ISP) objectives to determine each client's progress.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/9/13 at 4:00 PM. His ISP dated 6/13/12 indicated objectives to use walker correctly to prevent falling, speak at appropriate volume, identify coins prior to making purchases, identify 2 medications, participate in regular exercise, complete PT (physical therapy) exercises, safely remove lancet from the lancet device, evacuate to the correct location during drills, follow instructions, wear hearing aid daily, express frustration appropriately, join in activities, and improve personal hygiene skills. The record included a PM/QIDP review of client's objectives dated 2/1/13, but did not include other reviews.</p>	W000159	<p><b>Wind Ridge (WR) Recertification &amp; Licensure Survey Plan of Correction</b></p> <p><b>Survey Event ID D1KP11</b></p> <p><b>May/June 2013</b></p> <p><b>W159- Qualified Intellectual Disabilities Professional (QIDP)</b></p> <p>Bi-County Services, Inc. (BCS) will assure that each consumer's active treatment program is integrated, coordinated and monitored by a QIDP.</p> <p>This standard was not met as evidenced by QIDP failure of review &amp;/or revision of Wind Ridge (WR) consumers' Individual Support Plans (ISP) to determine each consumer's progress based on need &amp; outcomes. We understand that the QIDP role is pivotal to the quality of the programming each consumer receives. Thus the focus of our corrective action will be to ensure quality service design and delivery providing</p>	06/12/2013			

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	<p>Client #2's record was reviewed on 5/9/13 at 3:30 PM. His ISP dated 1/1/13 indicated objectives to use a walker at all times, identify one medication, participate in a variety of activities, improve coin awareness, engage in appropriate conversations, evacuate to the correct location, brush teeth in the morning, evening and at noon, exercise 20 of 26 days, and verbally express how he feels. The record included a PM/QIDP review of client's objectives dated 2/1/13, but did not include other reviews.</p> <p>Client #3's record was reviewed on 5/9/13 at 2:35 PM. His ISP dated 12/11/12 indicated objectives to blend water safely, show staff the fiber orange he takes, exit to the correct location for emergency evacuation, make a purchase, brush his teeth in the morning and the evening, participate in various activities, and purchase items of his choice. The record did not include a review of client #3's objectives by the PM/QIDP.</p> <p>Client #4's record was reviewed on 5/9/13 at 12:58 PM. His ISP dated 5/1/12 indicated objectives to focus on completing his shower, exit to the correct location, prepare breakfast, purchase items, brush teeth in the morning and the evening, identify medications, complete</p>		<p>each consumer with appropriate active treatment programs through administrative mentoring, monitoring and re-training of the QIDP at the WR group home, as well as monitoring all QIDP's agency wide through systemic changes in our quality assurance oversight identified and implemented effective April 2013. Part of the facility practices related to quality assurance will focus on ensuring that all consumers services &amp; necessary interventions be developed &amp; implemented by competent QIDP's capable of quality service delivery. The priority role of the administration will be to monitor staff in the QIDP positions to assure that they are competent to judge &amp; supervise active treatment issues for the consumers on their caseload and to intervene in a timely manner as appropriate per situation when competency is not demonstrated. Timely review &amp;/or revisions to consumer ISP objectives to determine each consumers' progress through monthly reviews are the expectation for BCS QIDP's.</p> <p><b>A) Corrective action and follow-up specific to Consumers #1,2,3 &amp; 4:</b></p> <p>1. <b>Consumer #1. (Will be referred to as C1 henceforth in</b></p>		

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	<p>home exercise program exercises, participate in various activities, and take part in community outings. The record included a PM/QIDP review of client's objectives dated 2/1/13, but did not include other reviews.</p> <p>The PM/QIDP was interviewed on 5/9/13 at 3:08 PM. He indicated there were no reviews for the months of July 2012-December 2012 completed by the previous PM/QIDP and he was in the process of completing late reviews of the clients' objectives.</p> <p>Additional PM/QIDP reviews for clients #1, #2, #3, and #4 were reviewed on 5/9/13 at 3:55 PM. A review of client #1, #2, #3, and #4's objectives for the period of June-December, 2012 indicated "This summary is submitted late and is to generalize June through December 2012, for the responsible Program Manager for Berne homes, did not complete the monthly summaries."</p> <p>9-3-3(a)</p>		<p><b>the POC</b>). A review of C1's ISP, goals and data by Program Director was completed on 5/28/13 with recommendations for the QIDP when completing monthly review. His annual ISP is due on 6/12/13 for implementation start date. The QIDP will complete thorough monthly reviews for April/May to indicate accurate consumer progress and reflect revisions/additions needed for his new ISP effective 6/12/13. Goals/objectives data reviewed indicate that there were lapses in targeted programming goals identified in the ISP dated 6/13/12, which should have been "caught" and remedied had it been monitored consistently by a competent QIDP. In the future, thorough monthly reviews will be completed by the QIDP by the 15<sup>th</sup> of each month and submitted to a member of the Administrative Quality Assurance Team (AQAT) for review &amp; recommendations to assure that C1's active treatment program is integrated, coordinated and monitored. The AQAT is composed of the Program Director (PD), Residential Administrator (RA) and Administrative Assistant for Quality Assurance (AAQA). The AQAT will assure that the QIDP makes observations, reviews data and progress, and revises programs/plans based on individual need &amp; outcomes based on timely review. Monthly</p>				

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			<p>review documentation will address C1's life across all settings with timely follow-up (F/U) to recommendations prn. The new ISP will be ready for implementation by 6/12/13 and reflect an active treatment program that is integrated, coordinated and based on C1's identified needs, progress/performance, assuring adequate environmental supports &amp; assistive devices are present to promote independence.</p> <p><b>2. Consumer #2. (Will be referred to as C2 in this POC).</b> A review of C2's ISP, current goals/objectives and data was completed by the PD on 5/30/13 with recommendations for the WR QIDP to address in the monthly review for program revisions. April and May monthly reviews will be thorough and inclusive of current progress, needs, and assuring an integrated &amp; coordinated active treatment program. In the future, Monthly Reviews will be completed by the WR QIDP and submitted to an AQAT member by the 15<sup>th</sup> of each month allowing for opportunity to assure that the QIDP functions are being carried out to best meet C2's needs and not simply a "paper chase" type of review. The AQAT will then be able to assist with any training needs identified for the QIDP in order for them to do their job competently, thus assuring</p>		

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			<p>that C2's programming is pertinent.</p> <p>3. <b>Consumer #3.(Will be referred to as C3 in the POC).</b> A review of C3's ISP, current goals/objectives and data was completed by the PD on 5/29/13. The review indicated the importance of thorough monitoring of C3's programming and April &amp; May Monthly Reviews will be completed with revisions made and implemented in a timely manner. Any recommendations for revisions to his plan(s) will be completed by 6/12/13. An AQAT member will provide oversight of the monthly reviews to assure that C3's plan is pertinent and appropriate to his needs.</p> <p>4. <b>Consumer #4.</b>On May 14<sup>th</sup> 2013 Consumer #4 died unexpectedly of natural causes associated with cardiac arrest. The QIDP and Residential Manager(s) are gathering documents for submission to the Mortality Review Committee in coordination with Sharon Hudson of Liberty of Indiana/BQIS. The Mortality Review packet must be submitted by June 15<sup>th</sup> 2013.</p> <p>5. The WR QIPD's office has been moved to the facility's main office area, where Day Services (DS) program is also located. This will allow for the QIDP to have supports provided</p>		

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			<p>consistently and in a timely manner by AQAT and peers allowing for regular mentoring, training and monitoring.</p> <p>6. The WR QIDP will submit monthly reviews of all consumers on their caseload by the 15 th of each month to an AQAT member for review &amp; guidance. The monthly review monitoring will continue for at least 120 days and then be reviewed for continued need for close monitoring The Residential Manager will assist with training of staff on any program additions &amp;/or revisions in a timely manner. Direct Care Staff (DCS) working with WR consumers will receive training regarding any program revisions as a result of the April/May monthly reviews by 6/12/13.</p> <p>Person's responsible: PD, RA, AAQA and WR QIDP and Residential Manager (RM).</p> <p>Target Completion Date: 6/12/13</p> <p><b>B) Corrective action as it relates to BCS practices agency wide relating to QIDP expectations and monitoring:</b></p>		

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			<p>1. Effective May 1<sup>st</sup> 2013 systemic changes were made to how administration provides oversight for quality assurance (QA) in a proactive manner, rather than "putting out fires". This process is proactive in reviewing priority plans to implement (plans identified for 5/1/13 QA oversight included ISP's, Risk Plans (RP), Consumer Specific Training (CST) and any procedures and protocols) to assure quality care &amp; service delivery for all consumers to meet individual needs and assure health, safety and well-being. Effective 6/1/13 the AQAT will monitor monthly reviews as part of this process to assure that consumers receive active treatment programs that are integrated, coordinated and monitored by competent QIDP's for the next 60 days. Any QIDP identified with needs for support and/or remediation will receive ongoing monitoring of monthly reviews until such time that competency is demonstrated consistently. All management team members for SGL and Supported Living will be re-trained on the procedure of submitting pertinent plans in a timely manner, with the addition of monthly review expectations/time lines.</p>		

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			Person's Responsible: PD; RA; AAQA and QIDP's.  Target completion date: 6/12/13	

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W000249	<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 observation, record review, and interview for 1 of 4 sampled clients (client #4), the facility failed to implement his behavior plan as written.</p> <p>Findings include:</p> <p>Observations were completed in the group home on 5/8/13 from 4:12 PM until 6:05 PM. Client #4 got a single serve chocolate pudding container out of the cupboard at 5:40 PM. Staff #7 removed it from his hand and told him another client's name was on the pudding. When client #4 asked for pudding again and attempted to reach in the cupboard for the pudding, staff #7 blocked client #4's attempts to get in the cupboard and indicated client #4 had just had pudding. Client #4 was offered a can of oranges instead which he ate. At 5:50 PM client #4 got another single serving container of chocolate pudding out of the cupboard and staff #13 took it from his hand and stated, "It's time to go," as client #4 indicated he wanted</p>	W000249	<p><b>W249-Program Implementation</b></p> <p>As soon as the IST has developed a consumer's ISP, each consumer must receive continuous active treatment programming consisting of needed interventions &amp; services in sufficient number &amp; frequency to support the achievement of objectives identified in the ISP.</p> <p>BCS was found to be deficient in not meeting this standard as evidenced by failing to implement a behavior support plan (BSP) as written.</p> <p>As noted in the W159 tag citation, Consumer #4, whose BSP was not implemented as written, died unexpectedly on May 14<sup>th</sup> 2013. Although we will not be addressing Consumer #4 specifically for this citation, we will direct the POC focus of corrective action toward assuring that the</p>	06/12/2013			

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	<p>the pudding. At 6:00 PM, client #4 was given vanilla pudding which he ate.</p> <p>Client #4's record was reviewed on 5/9/13 at 12:58 PM. Client #4's Behavior Support Plan (BSP) dated 5/1/13 indicated client #4 had obsessive compulsive disorder related behavior and behavior definitions included theft defined as taking another person's property, usually a pop or food item. The plan indicated client #4 "MUST HAVE...second helpings," and "MUST NOT HAVE the following in his environment to be successful...power struggles over objects, i.e., the phone, pop, food items...at snack time give him choices. [Client #4] is not overweight so if he would like a banana or yogurt rather than the same snacks others are having, that's fine...When [client #4] is engaged in any of the behaviors defined in the 'Behavior Definitions,' staff will ask [client #4] 'What are we supposed to be doing now?,' 'Is that an appropriate behavior,' or '[Client #4] I'm not going to take the phone, pop, or whatever item away,' 'Is this a good choice?,' etc. The above statements put the responsibility back on [client #4] and allow him an opportunity to arrive at the correct answer himself (empowerment)." Client #4's nutritional assessment dated 2/11/13 indicated client #4 was to receive a</p>		<p>potential of deficient practice(s) related to not implementing plans as written will not recur. Three other citations within this POC, including W tags 340, 368 &amp; 369 all relate to agency practices of assuring implementation of consumer plans/protocols as written, ensure that staff implements the training provided to prevent health &amp; behavior concerns and to administer medications per physician's orders.</p> <p>Assuring that staff implement, practice, reinforce and otherwise carry out strategies and procedures to achieve consumers objectives be they developmental, health, safety &amp;/or behavioral in nature is the responsibility of the administrative team. Residential Management Teams (RMT) and the medical department. We will assure that training is provided to staff that allows them to do their jobs competently <b>and</b> consistently and then monitor thereafter that plans are being implemented as written.</p> <p><b>A) Corrective Action and Follow-up specific to WR group home:</b></p> <p><b>1.BSP's.</b> Prior to BSP's being implemented once approved by</p>		

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	<p>regular diet and had lost 11 pounds in 3 months and 11 pounds in 6 months. The report indicated his weight loss was acceptable and weight was within normal weight range. Client #4 was to receive a nutritional supplement if he ate less than 50% of his meals and the only nutritional concern noted in the assessment indicated "poor posture when eating."</p> <p>The Program Director was interviewed on 5/9/13 at 4:30 PM and indicated staff should not have taken the pudding from client #4 and to do so was not implementing his behavior plan correctly, and staff should have followed the steps listed in his plan.</p> <p>9-3-4(a)</p>		<p>the Human Rights Committee (HRC), all staff working with WR consumers across are settings are trained by the 1 st of the month following the HRC meeting. Every two months at the WR house/staff meetings; all BSP's are reviewed along with any psychotropic medications taken by the WR consumers. BSP review(s) is an ongoing agenda item. This practice will continue.</p> <p>2.It is important that all staff is trained to competency. Training and competency are documented on the Group Home Training/Competency &amp; Day Services (DS) form provided through Human Resources. The training is done by the Residential Manager (RM), the QIDP and/or designated staff, but a RMT member is responsible for assuring the competency portion. There is a 90 day training/competency expectation with components that must be demonstrated within the 1 st 14 days of employment and there is an annual competency test which is completed at the time of DCS annual evaluation. This practice will be continued. (Reference HR Training/Competency form).</p> <p>3.It is the responsibility of the Berne RMT to follow-up/monitor all plans/protocols/agency practices to assure that they are being implemented as written, revise as needed, coordinate with other identified professional staff</p>		

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			<p>(RN's, Medical Case Worker, Administrative Team, other supervisory staff) to support DCS in implementing plans. The RMT &amp;/or other staff identified above <b><i>MUST intervene immediately should they observe that plans are not being implemented as written.</i></b></p> <p>4.All DCS working with WR consumers across all settings will be re-trained on understanding that failure to implement plans as written is considered <b><i>negligence</i></b> as per agency standard(s) as well as violation of the Abuse/Neglect/Exploitation and Violation of Individual Rights policy. Personnel Action will be taken with staff who does not implement plans as written. This action will be situational in nature and discretionary judgment used in the wide spectrum of addressing neglect from the possibility of retraining, to suspension from working with consumers and/or termination. Team input is a priority in determining personnel action required. All staff working with WR consumers will receive this re-training of consequences &amp; the agency A/N policy especially relating to neglect by June 10<sup>th</sup> 2013.</p> <p>5.All DCS will be encouraged to ask for clarification, training and any other supports needed for them to feel comfortable in doing their jobs competently and this will also be addressed during</p>		

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			<p>POC training by 6/10/13.</p> <p>Person's Responsible: Program Director (PD); RA; AAQA and WR RMT.</p> <p>Target Completion Date: 6/12/13</p> <p><b>B) Corrective Action as it relates to BCS practices agency wide:</b></p> <p>1. DCS working with group home consumers across all settings will be retrained on items A 4 &amp; 5 listed above in order to clarify expectations and consequences and encouragement to ask for help prn by 6/10/13.</p> <p>2.RMT's, supervisory staff working with SGL consumers across all settings, medical staff and administrative staff will be re-trained on items 1-5 above at an RMT meeting scheduled for June 3<sup>rd</sup> 2013. Any identified staff not attending the RMT Meeting will be trained on the targeted items by an administrative staff by 6/12/13.</p> <p>3.RMT's will assure that all SGL DCS are trained on items A 4 &amp; 5 by 6/12/13. DS DCS will be trained by the DS Coordinator &amp;/or PD by 6/10/13.</p>		

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			<p>4.Supported Living Management Teams (SLMT) will be retrained on items A 1-5 above by 6/10/13 and they in turn will provide training to SL DCS at their next scheduled staff meetings.</p> <p>Person's Responsible: PD; RA, AAQA, DS Coordinator and RMT's</p> <p>Target Completion Date: 6/12/13.</p>		

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W000340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on record review and interview, the facility failed for 2 additional clients (clients #5 and #8) to ensure staff implemented training for the clients' skin protocols to prevent skin breakdown and failed to ensure staff implemented training for 3 of 4 sampled clients (clients #1, #2 and #4) and 3 additional clients (clients #5, #6 and #7) to administer medications per physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 5/8/13 at 1:50 PM. The following reports included allegations made by the group home's RN:</p> <p>1. A report dated 11/2/12 indicated an agency RN made an allegation of neglect involving client #8. It was reported client #8 had not been thoroughly cleaned from changing his incontinence aid and "it has contributed to skin break down of the</p>	W000340	<p><b>W340-Nursing Services</b></p> <p>Nursing services must include implementing with other members of the IST, appropriate protective &amp; preventative health measures that include, but are not limited to training staff and consumers as needed in appropriate health &amp; hygiene measures. BCS was found to be deficient in this standard as evidenced by failure of DCS to: <b>1)</b> implement healthy skin protocols to prevent skin break down for two consumers after having been trained on the protocols and <b>2)</b> failure to ensure staff implementation of "Living in the Community" Core A &amp; B training to administer medications as per physician's orders for six consumers. The agency RN's do an excellent job of teaching/training staff on nursing interventions, protocols, etc. and take seriously the responsibility for training all staff agency wide on the State mandated drug administration course. RMT's and Administrative Team will work closely with the nurses and Medical Case Worker to assist with monitoring of health related plans/protocols being implemented as written and</p>	06/12/2013			

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	<p>buttocks area." The report indicated an allegation of neglect had not been substantiated, but staff had been retrained on client #8's changing and healthy skin tracking. The report indicated client #8's skin break down was "likely because he was not cleaned well" by staff #14.</p> <p>A report dated 11/2/12 indicated an agency RN made an allegation of neglect involving client #5. It was reported client #5 had not been thoroughly cleaned from changing his incontinence aid. The report indicated an allegation of neglect had not been substantiated, but staff had been retrained on client #5's changing and healthy skin tracking. The report indicated "It is hard to explain how [client #5] would have BM (bowel movement) on him when he was showered after his last BM at 7:00 PM on 11/1/(12), and he was changed twice when he was wet," and indicated staff #14 was given a verbal warning for "probably not cleaning [client #5] well."</p> <p>The group home nurse was interviewed on 5/9/13 at 4:25 PM. She indicated clients #5 and #8 had a specific protocol for addressing their risk for skin breakdown and staff #14 had not followed the protocol the group home nursing services had developed and staff had been retrained to prevent future occurrences.</p> <p>2. The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 5/8/13 at 1:50 PM and included the following medication errors:</p> <p>For client #1: A report dated 3/30/13</p>		<p>ensuring that staff administer medications/treatments per physician's orders. In regards to medication errors, although we have several safeguards in place, including but not limited to Medication Error Review Team (MERT), Medication Administration Guidelines, Medication Administration Mentors (MAM), Check List for Transcribing Orders, Buddy Check System, Proper Med Pass Observation by RN's, Group Home Medication Tracking Procedure, Medication Storage Protocol for DS &amp; Sheltered Workshops and Medication Monitoring and Management Procedures for DS &amp; Workshops it is apparent that we need to re-organize ourselves in such a manner as to assess and address concerns relating to the number of errors still occurring so as to assure that medications &amp;/or treatments are administered in compliance with physician's orders. Our protocols and other safeguards will be reviewed and revised as needed to aggressively pursue and implement ongoing monitoring with outcome focus on ending recurrence of medication errors. The agency RN's are working with our pharmacy, Young at Heart (YAH), in pursuing an EMAR system (One MAR) and will be visiting a group home in Indianapolis where the system is up &amp; running to assess the potential for BCS. The visit is</p>				

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	<p>indicated client #1 was to receive Tylenol 325 mg (milligrams) 3 times daily for shoulder pain diagnosed on 3/15/13, then to resume PRN (as needed only). The report indicated the physician's order was not correctly transcribed on the MAR (medication administration record) and resulted in errors including on 3/26/13, the 6 PM dose was not administered, on 3/27/13, the noon and 6 PM doses were not administered, on 3/28/13 the 6 PM dose was not administered, on 3/29/13 the noon and 6 PM dose were not administered. The report indicated staff were re-trained on checking medication administration for accuracy, and on correct, accurate transcribing.</p> <p>For client #4: A report dated 6/22/12 indicated client #4 received the wrong dose of Diltiazem (cardiovascular agent). A new order as of 6/22/(12) was given for 90 mg (milligrams) twice daily. Staff administered the 90 mg dose as well as the older order for 60 mg at HS (bedtime). The report indicated staff were retrained on the procedures to administer medication without error.</p> <p>For client #2: A report dated 4/17/13 indicated client #2 received 325 mg of Tylenol at bedtime in error. Staff had not compared the blister pack of the medication (with label) to the MAR and</p>		<p>scheduled for June 11 th 2013 with our two RN's &amp; Medical Caseworker participating along with a YAH pharmacist. The WR group home has been designated as the location to do a trial EMAR set-up once it has been designed for our agency's needs by the RN's, Medical Caseworker and YAH pharmacy representative. In addition, we will be trying out multi-dose blister packs per YAH recommendation at WR as options to reduce medication errors. Due to insurance issues with certain medications the multi-dose packs will not be available to us until cycle fill in mid-June and will be refilled every 7 days, as opposed to the monthly medication turnaround.</p> <p><b>1. Corrective action &amp; follow-up specific to Consumers # 8 &amp; 5 relating to <u>Healthy Skin Protocols</u>.</b></p> <p><b>Consumer #8 (C8): 1.</b> Regarding allegations of neglect, which were found to be unsubstantiated, staff re-training was required to assure that C8's healthy skin protocol (HSP) was implemented as written so that skin break down does not occur. As a result of the investigation into neglect allegations, staff was re-trained on HSP, tracking sheet was revised and Buddy Checks were added to monitor/assist in assurance that C8 is changed as per protocol. C8's HSP &amp; tracking sheets will be reviewed and revised prn by RN and PD/QIDP</p>				

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	<p>were retrained on medication administration.</p> <p>For client #5:</p> <ul style="list-style-type: none"> <li>- A report dated 7/1/12 indicated client #5 was given Simvastatin (cholesterol lowering medication). The medication was not part of his medication regime and was another client's medication. Staff were retrained on medication administration.</li> <li>- A report dated 9/28/12 indicated client #5 was prescribed Neomyein Polymyxin ear drops three times daily to treat an ear infection in his left ear, but staff wrote the order incorrectly in the MAR, indicating he was to receive the medication in his right ear. Client #5 received the medication in the wrong ear on 9/27/12 and 9/28/12. The report indicated a medication error review team would review the error to take steps to prevent future errors.</li> <li>- A report dated 2/26/13 indicated client #5 was prescribed Keflex (anti-biotic) to start 2/25/13, but it was not started until 2/26/13 due to a miscommunication between group home, medical staff and the Program Manager (PM). All staff will be retrained on medication administration and on call procedures concerning medication.</li> <li>- A report dated 4/2/13 indicated client #5 received 3 drops of Neomycin Promyxyyn</li> </ul>		<p>as part of this POC. All DCS working with C8 across all settings will be retrained on any revisions to his HSP &amp; tracking sheets by 6/10/13. <b>Consumer #5 (C5):</b> 1. As noted above for C8, the same allegations of neglect due to skin breakdown occurred on the same date/time for C5 as C8 due to the same staff person being involved in the changing process for both consumers on the morning of 11/2/12. As noted above, the staff member was re-trained on the HSP, the tracking sheet was revised and Buddy Checks were started to assure implementation of the HSP consistently. Due to many changes in C5's adaptive equipment including a new wheelchair that better meets his needs; consultation with health care professionals regarding his CP with spasticity concerns/needs and PT assessments with recommendations, C5's HSP &amp; tracking sheet is being revised to include the recommendations &amp; will be implemented following RN &amp;/or RMT providing all staff working with him across all settings by 6/10/13.</p> <p><b>1. Corrective Action and follow-up specific to Consumers # 1, 4, 2, 5, 6 &amp; 7 relating to <u>Medication Errors:</u></b></p> <p><b>Consumer #1 (C1):</b> 1. C1 had a medication error over a 3 day period for Tylenol 325 mg 2 tabs TID order due to shoulder pain</p>		

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	<p>which was an expired prescription at day services due to staff not sending the correct medication. Staff were retrained on communication between the group home and day services regarding medications that are transported between the group home and day services.</p> <p>For client #6: - A report dated 6/19/12 indicated at the 11:00 AM medication administration at day services, client #6 was given 2 Thertotab tablets (salt supplement-dosage not indicated) instead of one tab. Staff were retrained. - A report dated 7/5/12 indicated client #6's 12:00 PM dosage of Pot Chloride Cap (potassium supplement) 10 mg had been administered in error on four separate occasions while at Day Services on 6/14/12, 6/21/12, 6/22/12, and 7/2/12. Client #6 was given a single capsule when he was to receive two; by the same unidentified staff. Staff was retrained. - A report dated 7/27/12 indicated client #6 was given 150 mg of Seroquel (anti-psychotic) in the AM which was the evening dose instead of 50 mg as prescribed. Staff were retrained on medication administration procedures. - A report dated 7/22/12 indicated client #6 was given only 2 of the 3 tabs of Divalproex (seizures/mood stabilizer). Staff were retrained on medication</p>		<p>which was ordered by his physician on 3/25/13 for 4 days and then return to his regular prn order. The error was a result of incorrect transcription of physician's order to the MAR. Four DCS administered the medication incorrectly over the 4 day period and it was not "caught" during Buddy Checks &amp;/or by following the six rights of medication administration. Verbal warnings were given to three of the DCS and a one day suspension was given to a fourth staff member. RN's provided training at the WR group home within days of the error being found on transcribing orders. The same training was provided for all residential group home staff at each homes next regularly scheduled monthly "house" meetings. New PRN tags were developed as a visual aid when there is a change of a PRN to Routine medication(s) order and a Checklist for Transcribing Orders was developed and implemented effective 5/13 that includes a buddy checker for the staff person transcribing the orders. C1 suffered no adverse reactions as a result of this error and had no complaints of pain during the time frame. His primary care physician (PCP) was notified of the error and had no recommendations for follow-up (F/U). <b>Consumer #4 (C4):</b> 1. C4 was given an additional dose of Diltiazem (cardiovascular</p>				

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	<p>administration. A report dated 6/18/12 indicated staff failed to administer his Thermotab at 11:00 AM while at day services. Staff were retrained.</p> <p>- A report dated 8/16/12 indicated client #6 received his 5 mg Amlodipine (blood pressure) at 7 PM instead of 7:00 AM the following day as ordered. Staff were retrained. A report dated 8/31/12 indicated client #6 did not receive his 7:00 AM Adderall as prescribed in the hospital. The report indicated the error would be analyzed to determine corrective action.</p> <p>- A report dated 9/16/12 indicated client #6 was not given Simvastatin as there was no medication available in the group home to give him. The report indicated the medication had not been ordered in error. Staff were disciplined and retrained.</p> <p>- A report dated 11/15/12 indicated client #6 was prescribed Keflex 250 mg 15 ml (milliliters) suspension, 2 teaspoons twice daily and 2 tablespoons were administered instead of 2 teaspoons. Staff were retrained and cups were marked in a clearer fashion to prevent future errors.</p> <p>For client #7: -A report dated 9/18/12 indicated staff failed to give client #7 his 2 PM dose of Carafate 1 mg for gastric pain. The error was discussed with staff. -A report dated 11/25/12 indicated staff</p>		<p>agent) at HS med pass following a change in medication dosage on 6/22/12. Directives were provided to all group homes from nursing staff to pull all old medications and send in to the medical department on the next business day when a new order arrives so as to decrease confusion related to different orders for the same medication. C4's blood pressure was monitored throughout the night and remained stable with no ill effects noted. PCP notified by RN with no further instructions for F/U. Staff was re-trained on the 6 rights of med administration. All WR DCS were retrained in a timely manner on the importance of pulling meds no longer prescribed when there is a med change in order to avoid potential for recurrence of error.</p> <p><b>Consumer #2 (C2):</b> 1. Tylenol 325 mg tab was given to C2 at HS on 4/16/13; the med is prescribed routinely for 5 PM daily. Six rights were not followed by staff dispensing medications. C2 had no ill effects from the medication error &amp; PCP had no instructions for F/U. The Medication Error Review Team (MERT) met on 4/23/13 with recommendations for staff administering medications, as well as the staff doing Buddy Checks to receive verbal warnings. Training &amp; monitoring was also completed with both staff by the WR Medication</p>				

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	<p>failed to give client #7 his 2 PM dose of Carafate 1 mg. An alarm was set to remind staff to give the medication at 2 PM.</p> <p>-A report dated 1/3/13 indicated client was given an extra dose of Vitamin C at 7:00 PM because the medication pack was placed in his 7:00 PM medications. Staff were retrained.</p> <p>-A report dated 1/24/13 indicated client #7 received an extra dose of Carafate 1 mg at 2 PM. Staff were retrained.</p> <p>-A report dated 1/31/13 indicated client #7 was prescribed Septra DS for his current urinary tract infection and the medical department ordered staff to pick up the medication before the store closed. Staff failed to pick up the medication before the store closed. Staff were retrained on following the directions of the medical department and medication administration.</p> <p>-A report dated 2/4/13 indicated client #7 was given Ibuprofen for pain which was not his prescribed pain reliever. Staff on the morning shift will be utilized to dispense medication routinely to ensure clarity and maintain consistency and staff were retrained on medication administration.</p> <p>The group home nurse was interviewed on 5/9/13 at 4:25 PM. She indicated staff had recently been trained on medication</p>		<p>Administration Mentor (MAM). <b>Consumer #5 (C5):</b> 1. On 7/1/12 C5 received Simvastatin, a cholesterol lowering medication, which was another consumers medication &amp; not part of C5's drug regimen. Poison control was contacted and stated that C5 would be fine &amp; no monitoring was needed. PCP instructed staff to continue with current orders &amp; had no further instructions. C5 had no adverse reactions as a result of the error. Staff administering the medications was suspended from passing meds until 1-1 training with RN was completed to competency. Competency testing was also completed on the 6 rights of med administration. 2. C5 was prescribed Neomyein Polymyxin ear drops TID daily for an ear infection in his right ear. The order was transcribed wrong on the MAR to indicate drops to left ear rather than right ear and so he was given the drops in the wrong ear for two days (9/27 &amp; 9/28/12). The transcription error was not "caught" by the Buddy Checker either. MERT recommendations included procedure for WR to routinely fax orders, MAR's and transcription check lists to the RN for timely checks for accuracy. A very thorough Medication Transcription competency test was developed by the AAQA and RN's and completed with the staff administering medications at the</p>				

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	<p>administration and following policy and procedures for medication administration. She indicated there was additional training for this group home staff due to the high number of errors. She indicated staff are retrained when an error occurs, but it was up to staff to implement the training once it was received.</p> <p>9-3-6(a)</p>		<p>time of error, as well as the Buddy Checker. C5 has a history of ear infections. This infection lasted approximately 2 ½ weeks and he was seen by PCP for F/U appointments and medication additions &amp; changes during that time frame. (reference Medication Transcription competency test collateral). 3. C5 was prescribed Keflex 500 mg on 2/25/13 and was to be started immediately per medical staff orders due to ear infection. The medication was not started until the following morning as a result of not following medical directives and miscommunication with residential On-Call. Staff received a written warning with notice that any further medication errors would result in suspension. Staff was also re-trained on anti-biotic use and the importance of contacting the medical department &amp;/or Medical On-Call with questions about any medications. There were no adverse effects from the delayed administration of the anti-biotic.</p> <p>4. On 4/1/13 C5 received 3 Neomycin Promyxn HC ear drops in each ear for an ear infection from an expired prescription. The staff failed to triple check &amp;/or follow the six rights of medication administration. Staff received a one day suspension and a protocol was implemented for transporting medications between group homes and DS. C5</p>		

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			<p>suffered no adverse reactions as a result of the administration of drops from expired script and offered no complaints of discomfort/pain during this time frame. <b>Consumer #6 (C6):</b></p> <p>1. On 6/19/12 while at DS, staff administered 2 Thernatab tablets instead of one per physician's orders to C6. This medication is a salt supplement. Medical department provided instructions that his next dose scheduled for 3 pm not be given, due to the extra tab given at 11 AM. RN F/U with PCP indicated no further instructions. C6 did not suffer any adverse reactions as a result of the error. Training and competency testing on 6 rights of medication administration by the RM was completed on 6/22/12 with the staff in error of following physician's orders.</p> <p>2. On 7/5/12 it was discovered that C6 had been administered one Pot Chloride 10 mg cap at 12 noon, rather than the 2 caps prescribed, on four separate occasions while at DS by the same staff. He was to receive 2 caps at 12 noon daily rather than 1 cap. This is a potassium supplement. His PCP was notified and indicated that no harm would result from the error and to continue the medication as ordered. C6 did not suffer any adverse reactions as a result of the error. The staff who failed to administer the medication as ordered was re-trained by agency</p>		

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			<p>RN on 6 rights of med administration as well as given a competency test related to triple checks &amp; 6 rights. Training focus also included importance of checking for any script changes as part of the med pass process.</p> <p>3. On 7/27/12 AM med pass, C6 was given 150 mg of Seroquel, which is the HS dose, rather than 50 mg which is his routine AM dosage. RN's in consultation with the psychiatrist had staff administer the 50 mg AM dosage at HS to assure that he received the correct amount of medication for the day. There were no adverse effects from taking the larger dose of Seroquel in the AM. Staff administering the medications was suspended from administering medication until competency could be demonstrated. Competency testing was completed, as well as staff completing a narrative addressing reason for the error &amp; potential complications from administering wrong dose. Following competency testing, the RN completed two med administration observations with the staff, as well as an RN observation prior to the staff in error returning to unsupervised med passes.</p> <p>4. On 7/22/12, C6 was given 2 of 3 prescribed tabs of Divalproex (Depakote) 250 mg at 7 PM med pass. RN contacted PCP &amp; instructed to continue meds as prescribed. C6 had no adverse</p>		

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			<p>reactions as a result of not receiving the right dosage of the Depakote. RN provided retraining to the staff on 6 rights of medication administration and all WR staff was re-trained at next house meeting on Buddy Check responsibilities. On 6/18/12, C6 did not receive his 11 AM dose of Thermax while at DS. C6 had no adverse reactions from the missed dose &amp; instructions were given to continue with meds as prescribed. Medical Department provided re-training on Triple checks and 6 rights.</p> <p>5. On 8/16/12, C6 received 5 mg Almodipine (blood pressure med) at 7 PM rather than scheduled dose as ordered at 7 AM. There had been a change in the time that the med was to be given and staff erred due to not following the 6 rights. PCP was contacted and the medication was held for the following AM. C6 did not experience any adverse reactions as a result of the medication error. Also of concern were C6's increase in "acting out" due to rapid onset of dementia. His interactions with others have been a roller coaster of mood swings. Medication refusals, other health related treatment refusals and bouts with verbal &amp; physical aggression started to increase in August of 2012 and spiked later in the year. Staff involved with this error was retrained by the medical department with F/U by the RN on 6 rights. On 9/4/12 a</p>		

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			<p>protocol was developed by the RM with RN &amp; DCS input to assist staff with administering meds when refusals and aggression occur. All WR staff was trained on the new protocol by the RM on 9/5/12. At C6's annual case conference a need was identified for an ISP goal to address accepting medications without aggression. C6's new ISP was to be written for implementation by 9/1/12 by the previous QIDP. The QIDP did not complete his annual programming/ISP in a timely manner and the goal was not available for the staff to implement. In early November 2012, the PD discovered that his annual plan which was to be implemented effective 9/1/12 was not in place for staff to implement and a new med goal was written by the PD with the assistance of the medical department, RM and DCS and implemented in 11/12. The QIDP is no longer working for BCS due to failure to meet the responsibilities/criteria for the QIDP position.</p> <p>6. On 9/16/12, C6 was not given his 7 PM dose of Simvastatin 20 mg due to medication not being available as it was not re-ordered in a timely manner. No adverse reactions occurred as a result of the missed medication and it was available the following day (9/17/12). PCP instructed that medication be continued as prescribed. The MERT met on 9/18/12 and recommended that</p>		

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			<p>Buddy Checker be re-trained on pulling empty blister packs/med cards. A verbal warning was completed with the staff administering the medications at time of error. All WR staff was re-trained on proper procedures as it pertains to ordering medications and pulling empty med cards to assure re-ordering in a timely manner. Buddy checks on medications to be re-ordered to assure that all medications are available in the home were started at WR 10/12.</p> <p>7. On 11/15/12, C6 received 2 tablespoons of Keflex rather than 2 teaspoons as prescribed. The physician's order was for Keflex 250 mg 15 ml susp, 2 teaspoons PO BID. PCP was notified &amp; recommended to continue with med as prescribed &amp; was not concerned about adverse reactions as a result of the additional anti-biotic. Verbal warning was given to the staff administering medications. WR staff was trained on accurate measurements for liquid medications and the cups used to pour the liquid into were clearly marked for accurate portions for the duration of prescribed anti-biotic.</p> <p><b>Consumer #7 (C7):</b> 1. On 9/18/12, C7 did not receive his 2 PM dose of Carafate 1 gram for gastric pain. The med order is for 1 gram QID. The medication dose was missed as C7 was on an outing in the</p>		

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			<p>community and did not return home until after the med was to be administered. The staff did NOT check prior to leaving for the outing to assure that any meds needed were taken along with them. Due to the med being administered four times daily, this dose was "Held" and he then returned to regularly scheduled dosing at 7 PM on 9/18/12. There were no adverse reactions as a result of the error &amp; PCP had no instructions for F/U. The 2 staff involved were re-trained on taking medications with them during outings, as well as receiving verbal warnings related to administering medications as per physician's orders.</p> <p>2. On 11/25/12, C7 again did not receive his 2 pm dose of Carafate 1 gram QID for gastric pain. C7 had no negative outcomes from the missed medication &amp; PCP notified &amp; recommended continuing with medication as prescribed. Staff provided a written explanation for why/how the error occurred, received a verbal warning and had her own recommendation to set her phone alarm for med pass time for days that she does not typically work as an additional safeguard.</p> <p>3. On 1/2/13, C7 received an addition dose of Vitamin C which he is prescribed to take daily at 5 PM. He was given the 5 PM dose and then an additional dose at 7 PM. Staff did not follow the 6 rights of med administration, nor</p>		

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			<p>triple check meds prior to administration. The medication blister pack had been placed in the 7 PM med pass section, rather than returned to the routine 5 PM med section following the regular scheduled med pass. Verbal warning was given to staff administering medications. The RM also completed a med pass observation with the staff in error and found her to be competent in practicing the 6 rights.</p> <p>4. On 1/24/13, C7 received 2 doses of Carafate 1 gram QID at the 2 PM med administration time. He was picked up by WR DCS from DS to complete his regularly scheduled lab work. The medication had already been administered by DS staff prior to leaving for lab work. WR DCS also gave him the Carafate 1 gram without communicating with DS staff about med pass prior to taking C7 for his appointment. Due to the double dosing of the medication his 7 PM dose was "held" per PCP recommendation. PCP did not feel that there would be any harmful side effects due to the double dosage and there were no complaints offered by C7 from the med error. This is the 3rd Carafate error at the 2 PM administration time frame in the past four months. Verbal warning was given to the staff involved with giving the 2nd dose of the medication as well as re-training on the importance of communicating with other staff</p>		

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			<p>across all settings to clarify consumer medications, current status/needs and other general information related to health, safety &amp; well-being prior to leaving for appointments. There have been no further medication errors with Carafate, however should it recur; we will evaluate the time frames for the Carafate administration to see if there are other dosing times that would deter from the recurrence of this trend in 2 PM errors.</p> <p>5. On 1/31/13, C7 was prescribed Septra DS for a UTI. The medical department gave directions for staff to pick up the medication from the local pharmacy so that the prescription could be started immediately to benefit C7. Staff failed to pick up the prescription that evening and therefore the medication was not started until the following AM. This error is the 6th error for C7 in the past 2 months as noted by BQIS in their F/U request for information. It is also C7's 4th med error by staff during the month of January 2013. Part of the review of our MERT Guidelines for this POC will be a discussion of how we can identify trends in a timelier manner, so as to intervene quickly to correct concerns. Following medical orders is a priority and it cannot be stressed enough that staff need to clarify with medical department &amp;/or On-Call what they need to do and when,</p>		

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			<p>especially when there is a medication prescribed at appointments during the day that need to be started as soon as possible. Medication Administration Mentors (MAM) to support and assist staff with medication administration on the job was implemented 11/12 and this has been helpful in observing &amp; correcting problem areas that interfere with correct administration practices. The WR med administration area was re-organized in 12/12 to better meet the needs of staff administering meds and allowing for increased privacy for consumers. More storage areas were made available. No documentation was found on what personnel action was taken for the staff involved with not following through with medical departments directions on starting the medication on the date prescribed other than staff was re-trained on the importance of following directions from the medical department &amp; 6 rights of med administration. There were no adverse reactions noted as a result of starting the medication the following AM.</p> <p>6. On 1/31/13, C7 was given Ibuprofen prn after expressing complaints of pain in his groin area at 12:50 AM. Staff provided him with Ibuprofen from the "house" prn meds available and did not follow the 6 rights or triple check C7's prn medications for</p>		

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			<p>appropriate prescription/med to be given. His prn med for pain is Tylenol. He was monitored for adverse effects, with none noted. He had no further complaints. PCP was contacted with no F/U instructions needed. Verbal warning was given to staff involved with this error. Again, as noted in item #5 above as it relates to C7, it appears that we did not recognize the trend in errors during the month of January 2013 for C7 to address the concerns in a more proactive manner. We will re-assess MERT guidelines to see if there are components missing that need to be added to assure that consumers are free from neglect as it relates to medication administration error recurrence and identifying trends in a timelier manner.</p> <p><b>B) Corrective Action and Follow-up as it relates to WR &amp; BCS practices agency wide to eliminate recurrence of medication error(s):</b> 1. <b>WR.</b> In addition to corrective action identified in sections A &amp; B of the W340 tag, the following are actions indicated to assist with prevention of recurrence of concerns cited in the survey: a. Acquiring new storage cabinet to assist with separating &amp; organizing medications available 5/23/13. b. Designated site for trial EMAR system (One MAR) once designed for BCS needs by YAH pharmacy and medical</p>		

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			<p>department. c. Designated location for trial use of multi-dose medication packs effective June cycle fill. d. All staff working with WR consumers across all settings will be re-trained on A/N policy with focus on neglect issues of <b>NOT</b> administering medications as per physician's orders &amp;/or implementing health related plans/protocols as written. Explanation of consequences for neglect and importance of contacting the medical department &amp;/or Medical On-Call when needing clarification &amp;/or additional support/training. Reminder of the importance of following through with RN's directives regarding medications, treatments and plans/protocols as preventative resource for consumers' health &amp; safety. e. Retraining on Six Rights of Medication Administration &amp; Triple Checks. f. Review of the importance of the Buddy Check Procedure. g. Retraining on the importance of communication across all settings as it relates to consumers' health, safety &amp; well-being. <b>2. BCS Practices agency wide:</b> a. The implementation of the Medication Administration Mentor (MAM) system effective 11/12 has been an excellent "on the job" support for DCS in providing assistance with administration of medications/treatments/protocols/ plans in maintaining required documentation within the scope</p>		

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			of the agency policy & State mandated medication administration course "Living in the Community". We believe that this mentoring system will be successful in preventing recurrence of medication errors & assuring implementation of health related plans & protocols, including those designed by dieticians, physical & occupational therapists, etc. This practice will continue. b. BCS Medication Administration Guidelines has been reviewed with revisions identified. Revisions will be made & staff trained on them by 6/12/13. c. The Medication Error Review Team (MERT) Guidelines have been reviewed with revisions identified. Revisions will be made & staff trained on them by 6/12/13. · In addition, members of the MERT will be assessing & looking at new & better ways of identifying trends in a timelier manner in order to intervene & prevent recurrence. · The AAQA maintains an Employee Medication Error Record which is a tool that the MERT can refer to in identifying trends & concerns needing addressed. d. The agency RN's have developed a Medication Error Remediation Class that was designed to support, re-train and clarify issues leading to recurrence of errors. This additional support system has been appreciated by management teams, as well as		

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			DCS participating in the course. This practice will continue. e. A Group Home Medication Tracking System with specific responsibilities for 3 rd shift staff has been developed with daily, weekly & monthly "duties" which will assist with a variety of tasks such as checking for expired medications, proper labeling, ordering and monitoring of transcribing of orders. All residential 3 rd shift staff will be trained on the tracking system monitoring of "duties" to assist with recurring issues that can be prevented by 6/12/13. f. Agency RN's &/or Medical Caseworker complete a Proper Medication Pass Observation at least monthly in each group home. This observation allows for staff administering medications to clarify concerns with medical staff, while at the same time RN's can make recommendations related to any concerns identified during med pass and/or provide encouragement for staff doing an excellent job with following the 6 rights, etc. This practice will be continued. g. The Buddy Check Procedures will be reviewed and any identified revisions will be completed & staff trained on them by 6/12/13. h. A Checklist for Transcribing Orders has been developed and implemented 5/13. This tool to assure correct transcribing of orders also includes a staff to Buddy Check as an additional safeguard. All	

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			residential staff will be re-trained on the Checklist for Transcribing Orders by 6/12/13. i. A procedure for transporting &/or transferring of any consumer medications that might be "shared" across settings (group home & DS or workshops) has been identified as a need to assist with preventing errors. The procedure will be developed and staff trained across all settings prior to implementation no later than 6/10/13. j. The RMT's and other supervisory staff involved with residential consumers across all settings will be retrained on: · The A/N policy with focus on neglect issues tied in with recurrence of medication errors and failure to implement health related protocols & plans as written. · RMT responsibility to intervene immediately when needed to respond, investigate and correct situations with potential of consumer neglect. Our role is to prevent recurrence of problems/trends. · The Human Resources Competency Evaluation tool will be reviewed with the RMT's as well at a scheduled meeting on 6/2/13. · Re-training will also include the 6 rights, Triple Check & using the Buddy Check system as a prevention tool. · RMT's not in attendance at the scheduled meeting will be trained by an administrative team member no later than 6/10/13. · RMT's will be responsible for training their		

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			<p>staff on agenda items identified throughout this POC by 6/12/13.</p> <p>k. BCS Human Rights Committee (HRC) which meets every other month is an excellent resource for providing direction &amp; guidance related to residential consumer's medications, monitoring of drug interactions, as well as addressing concerns about errors. The HRC is made up of an attorney, pharmacist, retired physician, social worker, physical therapist, pastor and residential consumer. Their mission is to advocate for BCS consumers individual rights are not violated and that they are free from abuse, neglect &amp; exploitation</p> <p>l. Supported Living Management Teams (SLMT) will be trained on items listed in section C.2.j by 6/12/13. It will be the responsibility of the SLMT to assure that their staff are trained on these identified issues at the next scheduled staff meetings.</p> <p>Person's Responsible: PD, RN's &amp; Medical Caseworker, Administrative Team and RMT's.</p> <p>Target Completion Date: 6/12/13</p>		

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W000368	<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 for 3 of 4 sampled clients (clients #1, #2 and #4) and 3 additional clients (clients #5, #6 and #7) to administer medications per physician's orders.</p> <p>Findings include:</p> <p>The facility's incidents reported to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 5/8/13 at 1:50 PM and included the following medication errors:</p> <p>1. For client #1: A report dated 3/30/13 indicated client #1 was to receive Tylenol 325 mg 3 times daily for shoulder pain diagnosed on 3/15/13, then to resume PRN (as needed only). The report indicated the physician's order was not correctly transcribed on the MAR (medication administration record) and resulted in errors including on 3/26/13, the 6 PM dose was not administered, on 3/27/13, the noon and 6 PM doses were not administered, on 3/28/13 the 6 PM dose was not administered, on 3/29/13 the noon and 6 PM dose were not</p>	W000368	<p><b>W368-Drug Administration</b></p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>It is the intent of BCS that we meet the standard of drug administration, including the expectation that all drugs are administered in compliance with the physician's orders and are administered without error.</p> <p>BCS was found to be deficient in this standard as evidenced by failure to ensure that medications were administered per physician's orders for six consumers living at the WR group home. Our corrective action for this standard (W368) is inclusive in the W340 tag.</p> <p>Reference W340 Corrective Action relating to medication errors and F/U for consumers #1, 2, 4, 5, 6 and 7 Section B and the</p>	06/12/2013			

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	<p>administered. The report indicated staff were re-trained on checking medication administration for accuracy, and on correct, accurate transcribing.</p> <p>2. For client #4: A report dated 6/22/12 indicated client #4 received the wrong dose of Diltiazem (cardiovascular agent). A new order as of 6/22/(12) was given for 90 mg (milligrams) twice daily. Staff administered the 90 mg dose as well as the older order for 60 mg at HS (bedtime). The report indicated staff were retrained on the procedures to administer medication without error.</p> <p>3. For client #2: A report dated 4/17/13 indicated client #2 received 325 mg of Tylenol at bedtime in error. Staff had not compared the blister pack of the medication (with label) to the MAR and were retrained on medication administration.</p> <p>4. For client #5: - A report dated 7/1/12 indicated client #5 was given Simvastatin (cholesterol lowering medication). The medication was not part of his medication regime and was another client's medication. Staff were retrained on medication administration. - A report dated 9/28/12 indicated client #5 was prescribed Neomyein Polymyxin</p>		<p>WR group home Section C.1.a-g. Reference W340 Corrective Action as it relates to BCS practices agency wide Section C.2.a-l.</p> <p>Person's Responsible: PD, RN's &amp; Medical Caseworker, Administrative Team and RMT's.</p> <p>Target Completion Date: 6/12/13</p>				

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	<p>ear drops three times daily to treat an ear infection in his left ear, but staff wrote the order incorrectly in the MAR, indicating he was to receive the medication in his right ear. Client #5 received the medication in the wrong ear on 9/27/12 and 9/28/12. The report indicated a medication error review team would review the error to take steps to prevent future errors.</p> <p>- A report dated 2/26/13 indicated client #5 was prescribed Keflex (anti-biotic) to start 2/25/13, but it was not started until 2/26/13 due to a miscommunication between group home, medical staff and the Program Manager (PM). All staff will be retrained on medication administration and on call procedures concerning medication.</p> <p>- A report dated 4/2/13 indicated client #5 received 3 drops of Neomycin Promyxyn which was an expired prescription at day services due to staff not sending the correct medication. Staff were retrained on communication between the group home and day services regarding medications that are transported between the group home and day services.</p> <p>5. For client #6:</p> <p>- A report dated 6/19/12 indicated at the 11:00 AM medication administration at day services, client #6 was given 2 Thermotab tablets (salt</p>						

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	<p>supplement-dosage not indicated) instead of one tab. Staff were retrained.</p> <ul style="list-style-type: none"> <li>- A report dated 7/5/12 indicated client #6's 12:00 PM dosage of Pot Chloride Cap (potassium supplement) 10 mg had been administered in error on four separate occasions while at Day Services on 6/14/12, 6/21/12, 6/22/12, and 7/2/12. Client #6 was given a single capsule when he was to receive two; by the same unidentified staff. Staff was retrained.</li> <li>- A report dated 7/27/12 indicated client #6 was given 150 mg of Seroquel (anti-psychotic) in the AM which was the evening dose instead of 50 mg as prescribed. Staff were retrained on medication administration procedures.</li> <li>- A report dated 7/22/12 indicated client #6 was given only 2 of the 3 tabs of Divalproex (seizures/mood stabilizer). Staff were retrained on medication administration. A report dated 6/18/12 indicated staff failed to administer his Thermotab at 11:00 AM while at day services. Staff were retrained.</li> <li>- A report dated 8/16/12 indicated client #6 received his 5 mg Amlodipine (blood pressure) at 7 PM instead of 7:00 AM the following day as ordered. Staff were retrained. A report dated 8/31/12 indicated client #6 did not receive his 7:00 AM Adderall as prescribed in the hospital. The report indicated the error would be analyzed to determine</li> </ul>			

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	<p>corrective action.</p> <p>- A report dated 9/16/12 indicated client #6 was not given Simvastatin as there was no medication available in the group home to give him. The report indicated the medication had not been ordered in error. Staff were disciplined and retrained.</p> <p>- A report dated 11/15/12 indicated client #6 was prescribed Keflex 250 mg 15 ml (milliliters) suspension, 2 teaspoons twice daily and 2 tablespoons were administered instead of 2 teaspoons. Staff were retrained and cups were marked in a clearer fashion to prevent future errors.</p> <p>6. For client #7:</p> <p>-A report dated 9/18/12 indicated staff failed to give client #7 his 2 PM dose of Carafate 1 mg for gastric pain. The error was discussed with staff.</p> <p>-A report dated 11/25/12 indicated staff failed to give client #7 his 2 PM dose of Carafate 1 mg. An alarm was set to remind staff to give the medication at 2 PM.</p> <p>-A report dated 1/3/13 indicated client was given an extra dose of Vitamin C at 7:00 PM because the medication pack was placed in his 7:00 PM medications. Staff were retrained.</p> <p>-A report dated 1/24/13 indicated client #7 received an extra dose of Carafate 1 mg at 2 PM. Staff were retrained.</p> <p>-A report dated 1/31/13 indicated client</p>						

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	<p>#7 was prescribed Septra DS for his current urinary tract infection and the medical department ordered staff to pick up the medication before the store closed. Staff failed to pick up the medication before the store closed. Staff were retrained on following the directions of the medical department and medication administration.</p> <p>-A report dated 2/4/13 indicated client #7 was given Ibuprofen for pain which was not his prescribed pain reliever. Staff on the morning shift will be utilized to dispense medication routinely to ensure clarity and maintain consistency and staff were retrained on medication administration.</p> <p>The group home nurse was interviewed on 5/9/13 at 4:25 PM. She indicated staff had recently been trained on medication administration and following policy and procedures for medication administration. She indicated there was additional training for this group home staff due to the high number of errors. She indicated staff are retrained when an error occurs, but it was up to staff to implement the training once it was received.</p> <p>9-3-6(a)</p>						

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W000369	<p><b>483.460(k)(2) DRUG ADMINISTRATION</b></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 record review and interview, the facility failed for 1 additional client (client #5) to administer his medication per physician's orders.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 5/8/13 from 4:12 PM until 6:05 PM. During the administration of medication at 4:36 PM, client #5 did not receive his Probiotic after staff noted the bottle of Probiotic was empty. He indicated the probiotic was a temporary medication, and stated to client #5, "You're done with it."</p> <p>A copy of client #5's physician's order dated 5/3/13 in the medical book was reviewed on 5/3/13 at 5:05 PM and indicated Probiotic BID (twice daily) #60 (60 pills).</p> <p>Staff #7 was interviewed on 5/8/13 at 4:50 PM. When asked about the physician's order for the Probiotic, staff #7 indicated client #5 was not going to take the medication long term and</p>	W000369	<p><b>W369-Drug Administration</b></p> <p>All drugs, including those that are self-administered, are administered without error.</p> <p>It is the intent of BCS that we meet the standard(s) of drug administration including the expectation that all drugs are administered in compliance with the physician's orders and are administered without error</p> <p>BCS was found to be deficient in this standard as evidenced by failure to administer Consumer #5's medication per physician's orders. Consumer #5's Probiotic BID was not given per physician's order. Consumer #5 was to take the medication until completed (60 pills). Staff administering medications did not follow the Six Rights of medication administration, nor complete triple check, or he would have been aware that there was a new bottle of medication available to complete the physician's order for dosing BID until 60 pills had been</p>	06/12/2013	

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	<p>reviewed client #5's 5/13 MAR. He indicated client #5 had completed the medication as there was a 0 in the pill count sheet for client #5's probiotic indicating there were no more probiotic pills.</p> <p>Client #5's 5/13 MAR was reviewed on 5/8/13 at 4:51 PM and indicated a 0 next to the medication count sheet for client #5's probiotic pills.</p> <p>Staff #7 was interviewed again on 5/8/13 at 6:00 PM and indicated he was in error regarding client #5's probiotic and there was a fresh bottle of probiotic pills in the group home for client #5. He indicated he was unaware of the bottle of probiotics available in the home until staff #12 pointed the medication's location out to him.</p> <p>Client #5's 5/13 MAR was reviewed again on 5/8/13 at 6:01 PM and a sheet stapled behind the medication count sheet indicated client #5 was to receive the probiotic twice daily in the AM and PM. The MAR documentation did not indicate the probiotic had been discontinued.</p> <p>The house manager was interviewed on 5/9/13 at 8:21 AM and indicated staff #7 should have turned the page after the medication count sheet for client #5's</p>		<p>administered. He was relaying on the med count sheet that noted zero pills left and did not follow the Medication Administration Guidelines. The MAR did not indicate that the medication had been discontinued and as such he should have pursued the 6 rights/triple check safeguards to assure that medications were administered per physician's orders. Due to peer support during the medication pass, the additional bottle of pills was discovered and the medication was administered within the time lines for the med pass. Consumer #5 has successfully completed his Probiotic prescription orders without error &amp; with no adverse effects. Again, it is important to emphasize that following the six rights &amp; triple checking would eliminate medication errors and prevent negligence.</p> <p>We feel that our corrective action identified in the W340 tag is comprehensive and meets the action we would indicate for this citation as well. Staff #7 has been monitored by the RM &amp; WR MAM and they both feel that he has taken the importance of the six rights/triple checks in eliminating the potential for medication errors seriously. He has no record of medication errors</p>		

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	<p>probiotic count sheet in the MAR to see the probiotic listed in the MAR for administration twice daily had not been discontinued.</p> <p>The group home nurse was interviewed on 5/9/13 at 4:25 PM and indicated staff should have checked the MAR regarding client #5's probiotic medication and been aware of the medication refill's whereabouts.</p> <p>9-3-6(a)</p>		<p>Reference W340 corrective action relating to medication errors in the WR group home Section C.1.a-g and corrective action as it relates to BCS practices agency wide Section C.2.a-l.</p> <p>Persons responsible: PD, RN's &amp; Medical Caseworker, Administrative Team and RMT's.</p> <p>Target completion date: 6/12/13</p>		