

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G032	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/27/2014
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W CANAL ST WABASH, IN 46992
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 5/20, 5/21, 5/22, 5/23, and 5/27/2014.</p> <p>Provider Number: 15G032 Facility Number: 000592 AIM Number: 100233360</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/5/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client #2) and 2 additional clients (clients #5 and #7) who had personal money entrusted to the facility and had withdrawn canteen money from the bank, the facility failed to ensure a full</p>	W000140	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Handwritten receipts have been provided for all clients who were affected by the deficient practice.</p> <p><i>How you will identify other residents</i></p>	06/26/2014

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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	<p>accounting of client #2, #5, and #7's personal funds and failed to follow their policy and procedure for client finances.</p> <p>Findings include:</p> <p>On 5/21/14 at 10:15am, client #2, #5, and #7's personal funds and bank statements were reviewed with the Residential Manager (RM). The RM counted out client #2, #5, and #7's cash from their personal funds accounts in their individual cash bags and cash ledger records balanced for client #2, #5, and #7's cash accounts. No pop/canteen money was recorded. The RM was placing each client's personal cash on hand back into their individual bank bags and a separate baggie of change was inside client #2, #5, and #7's bank cash bags. The RM stated the baggie with loose change was "pop (canteen)" money. The RM counted separately in each bag client #2's loose "pop (canteen)" change to equal \$5.00, client #5's was \$4.50, and client #7's was \$4.50. The RM stated the facility did not track client #2, #5, and #7's "pop (canteen)" funds and no record for these funds was available for review. When asked where the loose change came from, the RM stated clients #2, #5, and #7 withdrew their "pop (canteen)" funds from their bank accounts when in the community with the facility staff and</p>		<p><i>having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All clients who use personal spending for items where an original receipt is not provided can be affected. Handwritten receipts will be completed for all clients if an original receipt is not available.</p> <p><i>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.</i></p> <p>Handwritten receipts will be completed for all clients if an original receipt is not available.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <p>The group home manager will review client's financial records on a monthly basis to ensure all receipts match up with expenditures.</p>				

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	<p>the facility staff kept each client's "pop (canteen)" money secured in the facility safe.</p> <p>On 5/23/14 at 8:55am, an interview with the RM and the Community Supports Coordinator (CSC) was conducted. The RM and CSC both indicated clients #2, #5, and #7's pop/canteen funds were not accounted for by the facility. The CSC indicated the facility did not follow the agency's policy and procedure to ensure a full accounting for each client's personal funds.</p> <p>On 5/21/14 at 12:00noon, the facility's policy and procedure 7/26/2011 "Personal Account and Petty Cash Guidelines" indicated "Many of our customers require assistance in handling their money. In providing this service, it is our responsibility to provide controls to safeguard their monies...You are expected to obtain an original store receipt for every purchase...For personal accounts, when receipts are unavailable for things such as for church offerings, purchases at a concession stand, etc. a hand written receipt must be created and initialed by both staff and client. All transactions should be recorded on the personal account sheet including money taken out for clients' personal use...."</p>				

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W000149	<p>9-3-2(a)</p> <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. Based on interview and record review, for 1 of 1 allegation of substantiated staff to client abuse and mistreatment (for clients #1, #2, #4, #5, #6, and #7), the facility neglected to implement its Abuse/Neglect/Mistreatment policy to immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law for clients #1, #2, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>On 5/20/14 at 11:20am, the facility's BDDS reports from 5/2013 through 5/20/14 were reviewed and indicated the following staff to client allegations of abuse, neglect, and/or mistreatment:</p> <p>For clients #1, #2, #4, #5, #6, and #7. -A 12/12/13 BDDS report for an incident on 12/11/13 at 11:30am, indicated Discharged Staff #1 was suspended on 12/12/13 pending an investigation and the "Residential Manager (RM) informed</p>	W000149	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Immediate corrective actions were taken. BDDS report was completed on 12/11/13. DSP who was accused of abuse was suspended 12/12/13 pending investigation. RM was written up on 12/12/13 due to not reporting incident to CSC immediately. DSP was terminated on 12/16/14.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients could be affected. All staff, including RM, were re-trained on Pathfinder Services' Abuse and Neglect Policy on 12/18/14. RM and CSC met and will continue to meet 1-2 times per month to discuss any issues in the home, as well as client and staff issues. Last meeting was held on 6/10/14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.</p>	06/26/2014			

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	<p>the Community Supports Coordinator on 12/11/13 of the following information:"</p> <p>-"It was reported that at 8:30am on 11/24/13 [Discharged Staff (DS) #1] was overheard saying to [client #2] If you can't talk then you shouldn't be doing anything fun! (sic). And don't come up to me later saying we're friends, because that's NOT (sic) how it works! (sic)"</p> <p>-"At 9:00am [DS #1] was heard saying out loud, If you can't do things on your own, then you need to go to a nursing home like [name of Discharged client #8]."</p> <p>-"One staff noted that [DS #1] went to [client #7's] room and yelled at him to get ready for church after the client said he did not want to go. [DS #1] reportedly told another [client #6] that he looked like a slob and he couldn't wear short sleeves to church." The report indicated client #6 became upset and a different staff person assisted him to find a long sleeve shirt.</p> <p>-"Another staff stated that at 9am, she heard [DS #1] tell [client #6] that he couldn't go to church because he wanted to dress like a slob and nearly threw [client #6] into a behavior."</p>		<p>RM and CSC will meet on a monthly basis to discuss any issues in the home, as well as client and staff issues. The nurse will also continue to observe and monitor during her quarterly reviews. Last review was 5/22/14.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>RM and CSC will meet on a monthly basis to discuss any issues in the home, as well as client and staff issues. The nurse will also continue to observe and monitor during her quarterly reviews. Last review was 5/22/14.</p>	

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	<p>-"[DS #1] also reportedly told all the guys [clients #1, #2, #4, #5, #6, and #7] that she hopes Santa forgets them for Christmas because they are all naughty repeatedly. [DS #1] was also heard saying that if [the clients] can't do for themselves then they need to go to visit their friend [Discharged client #8] in the nursing home."</p> <p>-The report indicated "At 12:20pm, a staff reported that another staff told them about an incident where one client kicked another client on the previous day (11/23/13) and [DS #1] commented that he (the client who was kicked) probably deserved it, I would have to agree with the client who kicked him."</p> <p>-"At 12:35pm, in front of all the clients, [DS #1] reportedly said I think we need to find a nursing home for six guys that do anything! (sic)"</p> <p>-"At (the) lunch meal a staff reported that one of the clients forgot to pour water up at the bar table (for lunch) and [DS #1] went over and told him to pour them cause he forgot and said do I have to take your food away til you do it? The client, apparently did not get up so [DS #1] went to another client and told him that the client who forgot to pour the water wasn't his friend anymore cause he didn't pour</p>						

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	<p>you water. [DS #1] added to the client who did not pour the water, I hope Santa forgets you (sic)."</p> <p>-"Another staff reported that this incident happened at 12:40pm and what she heard was [DS #1] saying to one client who didn't pour the water, your best buddy doesn't want to be friends anymore, he doesn't want you to have any water, I hope Santa forgets some of you guys for Christmas! (sic)"</p> <p>-The report indicated "[DS #1] reportedly got very upset about a client's medication that had to be 30 minutes before a meal and one hour away from his iron pill because that would put them eating supper at 5:30pm to 6:00pm and [DS #1] did not want to wait that long so she came out and told all the guys to get ready to eat except [client #2]...When staff told her that they needed to wait for [client #2], staff reported that [DS #1] stated that we never wait, ever, and the client needs to just go to a nursing home then that's where he belongs with all the extra stuff."</p> <p>On 5/21/14 at 11:10am, a 12/16/13 "Investigation" indicated DS #1 was terminated from employment because of "Inappropriate interaction" with clients #1, #2, #4, #5, #6, and #7. The</p>				

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	<p>investigation indicated that on 12/5/13 "Staff brought concerns to the [Residential Manager] in regards to [DS #1's] interaction with clients on November 24, 2013." The investigation indicated the allegation documented in the 12/12/13 BDDS report was substantiated.</p> <p>On 5/21/14 at 11:10am, a 12/12/13 "Written Warning" for the Residential Manager indicated the facility staff reported an allegation of abuse, neglect, and/or mistreatment regarding clients #1, #2, #4, #5, #6, and #7 on 12/5/2013 and did not report the allegation to the facility's administrator (aka Community Supports Coordinator) "until Wednesday, December 11, 2013." The report indicated the Residential Manager (RM) did not immediately report the allegation. The report indicated the RM "was reminded that critical information like this must be dealt with immediately. Due to [RM name] not bringing the information to his supervisor sooner, the alleged staff was able to work two more days before the matter could be dealt with. [The RM] is to bring employee/client issues to his supervisor in a timely manner so as to meet state regulations as well as to keep our clients out of harms way."</p>						

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	<p>On 5/21/14 at 11:10am, Discharged Staff #1's "Timecard Report" for the period from 11/23/13 through 12/12/13 was reviewed and indicated Discharged Staff #1 worked at the group home on 11/23, 11/24, 11/25, 11/26, 12/2, and 12/9/13. The investigation failed to identify that Discharged Staff #1 continued to work at the group home after the incident occurred and was not suspended until after the RM notified the administrator on 12/11/13.</p> <p>On 05/21/14 at 1:05pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated the allegations of abuse, neglect, and/or mistreatment were not reported immediately to the administrator and in accordance with State Law. The CSC indicated suspected abuse, neglect, and/or mistreatment allegations should be reported immediately by the facility staff. The CSC indicated the multiple members of the facility staff who witnessed the events and failed to report the allegation exposed the clients to the potential of further abuse, neglect, and/or mistreatment because DS #1 continued to work during the period from 11/23/13 until 12/11/13. The CSC indicated the events occurred on 11/23/13 and were not immediately reported and additional events occurred on 11/24/13 and were not</p>						

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	<p>immediately reported. The CSC indicated once the facility staff did report the allegation on 12/5/13 to the RM, the RM did not immediately report the allegation to the administrator. The CSC indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment.</p> <p>On 5/20/14 at 11:42am, a review of the facility's records indicated the facility's undated "Handling client Abuse, Neglect, and Injuries of Unknown Origin & BDDS Incident Reporting" policy which indicated "It is Pathfinder Services, Inc. policy to provide a service where clients are free from abuse, neglect, or exploitation. In the event that any of these conditions are suspected, an investigation will immediately be conducted...Any alleged, suspected, or actual abuse-physical, sexual, emotional, or domestic improper treatment, neglect-failure to provide appropriate care, environment, food, medical care, or supervision, exploitation or any other mistreatment must be immediately reported. This should be reported to the supervisor who is serving as the administrator of and is therefore responsible for the oversight of the facility in which the individual is being served...."</p>			

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W000153	<p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review, for 1 of 1 allegation of substantiated staff to client abuse and mistreatment (for clients #1, #2, #4, #5, #6, and #7), the facility failed to immediately report an allegation of abuse, neglect, and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law for clients #1, #2, #4, #5, #6, and #7.</p> <p>Findings include:</p> <p>On 5/20/14 at 11:20am, the facility's BDDS reports from 5/2013 through 5/20/14 were reviewed and indicated the following staff to client allegations of abuse, neglect, and/or mistreatment:</p> <p>For clients #1, #2, #4, #5, #6, and #7. -A 12/12/13 BDDS report for an incident on 12/11/13 at 11:30am, indicated Discharged Staff #1 was suspended on</p>	W000153	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Immediate corrective actions were taken. BDDS report was completed on 12/11/13. DSP who was accused of abuse was suspended 12/12/13 pending investigation. RM was written up on 12/12/13 due to not reporting incident to CSC immediately. DSP was terminated on 12/16/14.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients could be affected. All staff, including RM, were re-trained on Pathfinder Services' Abuse and Neglect Policy on 12/18/14. RM and CSC met and will continue to meet 1-2 times per month to discuss any issues in the home, as well as client and staff issues. Last meeting was held on 6/10/14.</p>	06/26/2014			

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	<p>12/12/13 pending an investigation and the "Residential Manager (RM) informed the Community Supports Coordinator on 12/11/13 of the following information:"</p> <p>- "It was reported that at 8:30am on 11/24/13 [Discharged Staff (DS) #1] was overheard saying to [client #2] If you can't talk then you shouldn't be doing anything fun! (sic). And don't come up to me later saying we're friends, because that's NOT (sic) how it works! (sic)"</p> <p>- "At 9:00am [DS #1] was heard saying out loud, If you can't do things on your own, then you need to go to a nursing home like [name of Discharged client #8]."</p> <p>- "One staff noted that [DS #1] went to [client #7's] room and yelled at him to get ready for church after the client said he did not want to go. [DS #1] reportedly told another [client #6] that he looked like a slob and he couldn't wear short sleeves to church." The report indicated client #6 became upset and a different staff person assisted him to find a long sleeve shirt.</p> <p>- "Another staff stated that at 9am, she heard [DS #1] tell [client #6] that he couldn't go to church because he wanted to dress like a slob and nearly threw</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.</p> <p>RM and CSC will meet on a monthly basis to discuss any issues in the home, as well as client and staff issues. The nurse will also continue to observe and monitor during her quarterly reviews. Last review was 5/22/14.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>RM and CSC will meet on a monthly basis to discuss any issues in the home, as well as client and staff issues. The nurse will also continue to observe and monitor during her quarterly reviews. Last review was 5/22/14.</p>				

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	<p>[client #6] into a behavior."</p> <p>-"[DS #1] also reportedly told all the guys [clients #1, #2, #4, #5, #6, and #7] that she hopes Santa forgets them for Christmas because they are all naughty repeatedly. [DS #1] was also heard saying that if [the clients] can't do for themselves then they need to go to visit their friend [Discharged client #8] in the nursing home."</p> <p>-The report indicated "At 12:20pm, a staff reported that another staff told them about an incident where one client kicked another client on the previous day (11/23/13) and [DS #1] commented that he (the client who was kicked) probably deserved it, I would have to agree with the client who kicked him."</p> <p>-"At 12:35pm, in front of all the clients, [DS #1] reportedly said I think we need to find a nursing home for six guys that do anything! (sic)"</p> <p>-"At (the) lunch meal a staff reported that one of the clients forgot to pour water up at the bar table (for lunch) and [DS #1] went over and told him to pour them cause he forgot and said do I have to take your food away til you do it? The client, apparently did not get up so [DS #1] went to another client and told him that the</p>			

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	<p>client who forgot to pour the water wasn't his friend anymore cause he didn't pour you water. [DS #1] added to the client who did not pour the water, I hope Santa forgets you (sic)."</p> <p>-"Another staff reported that this incident happened at 12:40pm and what she heard was [DS #1] saying to one client who didn't pour the water, your best buddy doesn't want to be friends anymore, he doesn't want you to have any water, I hope Santa forgets some of you guys for Christmas! (sic)"</p> <p>-The report indicated "[DS #1] reportedly got very upset about a client's medication that had to be 30 minutes before a meal and one hour away from his iron pill because that would put them eating supper at 5:30pm to 6:00pm and [DS #1] did not want to wait that long so she came out and told all the guys to get ready to eat except [client #2]...When staff told her that they needed to wait for [client #2], staff reported that [DS #1] stated that we never wait, ever, and the client needs to just go to a nursing home then that's where he belongs with all the extra stuff."</p> <p>On 5/21/14 at 11:10am, a 12/16/13 "Investigation" indicated DS #1 was terminated from employment because of</p>						

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	<p>"Inappropriate interaction" with clients #1, #2, #4, #5, #6, and #7. The investigation indicated that on 12/5/13 "Staff brought concerns to the [Residential Manager] in regards to [DS #1's] interaction with clients on November 24, 2013." The investigation indicated the allegation documented in the 12/12/13 BDDS report was substantiated.</p> <p>On 5/21/14 at 11:10am, a 12/12/13 "Written Warning" for the Residential Manager indicated the facility staff reported on 12/5/13 an allegation of abuse, neglect, and/or mistreatment regarding clients #1, #2, #4, #5, #6, and #7. The report indicated the Residential Manager did not report the allegation to the facility's administrator (aka Community Supports Coordinator) "until Wednesday, December 11, 2013." The report indicated the Residential Manager (RM) did not immediately report the allegation. The report indicated the RM "was reminded that critical information like this must be dealt with immediately. Due to [RM name] not bringing the information to his supervisor sooner, the alleged staff was able to work two more days before the matter could be dealt with. [The RM] is to bring employee/client issues to his supervisor in a timely manner so as to meet state</p>						

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W000155	<p>regulations as well as to keep our clients out of harms way."</p> <p>On 05/21/14 at 1:05pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated the allegations of abuse, neglect, and/or mistreatment were not reported immediately to the administrator and in accordance with State Law. The CSC indicated suspected abuse, neglect, and/or mistreatment allegations should be reported immediately by the facility staff. The CSC indicated the multiple members of the facility staff who witnessed the events and failed to report the allegation. The CSC indicated the events occurred on 11/23/13 and were not immediately reported and additional events occurred on 11/24/13 and were not immediately reported. The CSC indicated once the facility staff did report the allegation on 12/5/13 to the RM, the RM did not immediately report the allegation to the administrator. The CSC indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential</p>			

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	<p>abuse while the investigation is in progress. Based on interview and record review, for 1 of 1 allegation of substantiated staff to client abuse and mistreatment (for clients #1, #2, #4, #5, #6, and #7), the facility failed to protect clients #1, #2, #4, #5, #6, and #7 from further abuse, neglect, and/or mistreatment after staff reported an allegation of abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>On 5/20/14 at 11:20am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/2013 through 5/20/14 were reviewed and indicated the following staff to client allegations of abuse, neglect, and/or mistreatment:</p> <p>For clients #1, #2, #4, #5, #6, and #7. -A 12/12/13 BDDS report for an incident on 12/11/13 at 11:30am, indicated Discharged Staff #1 was suspended on 12/12/13 pending an investigation and the "Residential Manager (RM) informed the Community Supports Coordinator on 12/11/13 of the following information" which occurred on 11/23/13, 11/24/13, and 11/25/13.</p> <p>-"It was reported that at 8:30am on 11/24/13 [Discharged Staff (DS) #1] was</p>	W000155	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</p> <p>Immediate corrective actions were taken. BDDS report was completed on 12/11/13. DSP who was accused of abuse was suspended 12/12/13 pending investigation. RM was written up on 12/12/13 due to not reporting incident to CSC immediately. DSP was terminated on 12/16/14.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <p>All clients could be affected. All staff, including RM, were re-trained on Pathfinder Services' Abuse and Neglect Policy on 12/18/14. RM and CSC met and will continue to meet 1-2 times per month to discuss any issues in the home, as well as client and staff issues. Last meeting was held on 6/10/14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.</p> <p>RM and CSC will meet on a monthly basis to discuss any issues in the home, as well as client and staff issues. The nurse will also continue to observe and monitor during her quarterly reviews. Last review was 5/22/14.</p>	06/26/2014			

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	<p>overheard saying to [client #2] If you can't talk then you shouldn't be doing anything fun! (sic). And don't come up to me later saying we're friends, because that's NOT (sic) how it works! (sic)"</p> <p>-"At 9:00am [DS #1] was heard saying out loud, If you can't do things on your own, then you need to go to a nursing home like [name of Discharged client #8]."</p> <p>-"One staff noted that [DS #1] went to [client #7's] room and yelled at him to get ready for church after the client said he did not want to go. [DS #1] reportedly told another [client #6] that he looked like a slob and he couldn't wear short sleeves to church." The report indicated client #6 became upset and a different staff person assisted him to find a long sleeve shirt.</p> <p>-"Another staff stated that at 9am, she heard [DS #1] tell [client #6] that he couldn't go to church because he wanted to dress like a slob and nearly threw [client #6] into a behavior."</p> <p>-"[DS #1] also reportedly told all the guys [clients #1, #2, #4, #5, #6, and #7] that she hopes Santa forgets them for Christmas because they are all naughty repeatedly. [DS #1] was also heard</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>RM and CSC will meet on a monthly basis to discuss any issues in the home, as well as client and staff issues. The nurse will also continue to observe and monitor during her quarterly reviews. Last review was 5/22/14.</p>	

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	<p>saying that if [the clients] can't do for themselves then they need to go to visit their friend [Discharged client #8] in the nursing home."</p> <p>-The report indicated "At 12:20pm, a staff reported that another staff told them about an incident where one client kicked another client on the previous day (11/23/13) and [DS #1] commented that he (the client who was kicked) probably deserved it, I would have to agree with the client who kicked him."</p> <p>-"At 12:35pm, in front of all the clients, [DS #1] reportedly said I think we need to find a nursing home for six guys that do anything! (sic)"</p> <p>-"At (the) lunch meal a staff reported that one of the clients forgot to pour water up at the bar table (for lunch) and [DS #1] went over and told him to pour them cause he forgot and said do I have to take your food away til you do it? The client, apparently did not get up so [DS #1] went to another client and told him that the client who forgot to pour the water wasn't his friend anymore cause he didn't pour you water. [DS #1] added to the client who did not pour the water, I hope Santa forgets you (sic)."</p> <p>-"Another staff reported that this incident</p>			

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	<p>happened at 12:40pm and what she heard was [DS #1] saying to one client who didn't pour the water, your best buddy doesn't want to be friends anymore, he doesn't want you to have any water, I hope Santa forgets some of you guys for Christmas! (sic)"</p> <p>-The report indicated "[DS #1] reportedly got very upset about a client's medication that had to be 30 minutes before a meal and one hour away from his iron pill because that would put them eating supper at 5:30pm to 6:00pm and [DS #1] did not want to wait that long so she came out and told all the guys to get ready to eat except [client #2]... When staff told her that they needed to wait for [client #2], staff reported that [DS #1] stated that we never wait, ever, and the client needs to just go to a nursing home then that's where he belongs with all the extra stuff."</p> <p>On 5/21/14 at 11:10am, a 12/12/13 "Written Warning" for the Residential Manager indicated the facility staff reported on 12/5/13 an allegation of abuse, neglect, and/or mistreatment regarding clients #1, #2, #4, #5, #6, and #7. The report indicated the Residential Manager did not report the allegation to the facility's administrator (aka Community Supports Coordinator) "until</p>						

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	<p>Wednesday, December 11, 2013." The report indicated the Residential Manager (RM) did not immediately report the allegation. The report indicated the RM "was reminded that critical information like this must be dealt with immediately. Due to [RM name] not bringing the information to his supervisor sooner, the alleged staff was able to work two more days before the matter could be dealt with. [The RM] is to bring employee/client issues to his supervisor in a timely manner so as to meet state regulations as well as to keep our clients out of harms way."</p> <p>On 5/21/14 at 11:10am, Discharged Staff #1's "Timecard Report" for the period from 11/23/13 through 12/12/13 was reviewed and indicated Discharged Staff #1 worked at the group home on 11/23, 11/24, 11/25, 11/26, 12/2, and 12/9/13. The investigation failed to identify that Discharged Staff #1 continued to work at the group home after the incident occurred and was not suspended until after the RM notified the administrator on 12/11/13.</p> <p>On 05/21/14 at 1:05pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated the multiple members of the facility staff who witnessed the events</p>			

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W000192	<p>and failed to report the allegation exposed the clients to the potential of further abuse, neglect, and/or mistreatment because DS #1 continued to work during the period from 11/23/13 until 12/11/13. The CSC indicated the events occurred on 11/23/13 and were not immediately reported and additional events occurred on 11/24/13 and were not immediately reported. The CSC indicated once the facility staff did report the allegation on 12/5/13 to the RM, the RM did not immediately report the allegation to the administrator. The CSC indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure staff were trained on client #3's heart pacemaker monitor station.</p> <p>Findings include:</p>	W000192	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>The Residential Nurse revised the Sick Sinus high risk plan for client #3's pacemaker. All staff have been trained on the new plan.</p>	06/26/2014

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	<p>On 5/20/14 from 3:15pm until 5:40pm and on 5/21/14 from 5:45am until 7:45am, observations and interviews were completed at the group home. During both observation periods a white monitoring station sat on a shelf in the dining room at eye level. The white console had a blue blinking heart in the center of the console. At 4:30pm, Group Home Staff #1 indicated the white monitoring station was for client #3's heart pacemaker. At 4:30pm, GHS (Group Home Staff) #1, GHS #3, and GHS #4 stated they had "no idea" what to look for or how to determine if client #3's white monitoring station was functional. The three staff indicated they had not been trained on client #3's heart pacemaker monitoring station. On 5/21/14 at 7:30am, GHS #2 indicated she had not been trained on client #3's heart pacemaker station.</p> <p>On 5/23/14 at 9:30am, an interview with the agency nurse was conducted. The agency nurse indicated the agency did not have a policy/procedure on how to monitor the new system and did not have staff responsibilities to monitor client #3's heart pacemaker station. The agency nurse indicated the facility staff had not received formal training on client #3's heart/pacemaker monitor. The agency nurse indicated the new system was</p>		<p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>Clients who have high risk plans have the potential to be affected by the same deficient practice. The Residential Nurse will continue to review the high risk plans quarterly and ensure all plans are in place based on each client's medical conditions.</p> <p><i>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.</i></p> <p>The Residential Nurse will continue to review the high risk plans quarterly and ensure all plans are in place based on each client's medical conditions. She will document when she does her reviews.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <p>The Residential Nurse will continue to review the high risk plans quarterly and ensure all plans are in place based on each client's medical conditions. She will document when she does her reviews.</p>				

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	<p>provided by the Cardiologist, hooked to a phone line, and operated with power of the phone and outlet. The agency nurse did not know if the system had a battery backup, if the system reset after a power surge/power outage, or if how the system was maintained. The agency nurse indicated client #3's pacemaker could be monitored on an ongoing basis not just every three (3) months by a phone hook up (which was the old system).</p> <p>Client #3's record was reviewed on 5/22/14 at 11:25am. Client #3's undated "Sick Sinus Syndrome Protocol" indicated "Sick sinus syndrome is the name for a group of heart rhythm problems/arrhythmias in which the sinus node, the heart's natural pacemaker doesn't work properly...Sick sinus syndrome is relatively uncommon, but the risk of developing sick sinus syndrome increases with age. Many people with sick sinus syndrome eventually need a pacemaker to keep the heart in a regular rhythm...Will be free from fast or too slow heart rhythm with use of indwelling pacemaker...Proactive/Preventative Supports and strategies to manage the risk: Cardiologist assesses client routinely and pacemaker checks done via phone usually every 3 months...." Client #3's plans did not include the use of the</p>			

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W000331	<p>new heart pacemaker monitoring station located in the facility's dining room.</p> <p>9-3-3(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility nursing staff failed to develop a protocol which included client #3's use of the new group home heart pacemaker monitor station.</p> <p>Findings include:</p> <p>On 5/20/14 from 3:15pm until 5:40pm and on 5/21/14 from 5:45am until 7:45am, observations and interviews were completed at the group home. During both observation periods a white monitoring station sat on a shelf in the dining room at eye level. The white console had a blue blinking heart in the center of the console. At 4:30pm, Group Home Staff #1 indicated the white monitoring station was for client #3's heart pacemaker. At 4:30pm, GHS (Group Home Staff) #1, GHS #3, and GHS #4 stated they had "no idea" what to look for or how to determine if client #3's</p>	W000331	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The Residential Nurse revised the Sick Sinus high risk plan for client #3's pacemaker. All staff have been trained on the new plan. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Clients who have high risk plans have the potential to be affected by the same deficient practice. The Residential Nurse will continue to review the high risk plans quarterly and ensure all plans are in place based on each client's medical conditions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The Residential Nurse will continue to review the high risk plans quarterly and ensure all plans are in place based on</p>	06/26/2014

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	<p>white monitoring station was functional. The three staff indicated they had not been trained on client #3's heart pacemaker monitoring station. On 5/21/14 at 7:30am, GHS #2 indicated she had not been trained on client #3's heart pacemaker station.</p> <p>On 5/23/14 at 9:30am, an interview with the agency nurse was conducted. The agency nurse indicated client #3's risk plans did not include a protocol on how staff were to monitor or responsibilities for client #3's new system for his heart pacemaker station. The agency nurse indicated the facility staff had not received formal training on client #3's heart/pacemaker monitor. The agency nurse indicated the machine was a new system and had not been incorporated into client #3's risk plans for his heart monitor/pacemaker. The agency nurse indicated the new system was provided by the Cardiologist, hooked to a phone line, and operated with power of the phone and outlet. The agency nurse did not know if the system had a battery backup, if the system reset after a power surge/power outage, or if how the system was maintained. The agency nurse indicated client #3's pacemaker could be monitored on an ongoing basis not just every three (3) months by a phone hook up (which was the old system).</p>		<p>each client's medical conditions. She will document when she does her reviews. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Residential Nurse will continue to review the high risk plans quarterly and ensure all plans are in place based on each client's medical conditions. She will document when she does her reviews.</p>				

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W000368	<p>Client #3's record was reviewed on 5/22/14 at 11:25am. Client #3's undated "Sick Sinus Syndrome Protocol" indicated "Sick sinus syndrome is the name for a group of heart rhythm problems/arrhythmias in which the sinus node, the heart's natural pacemaker doesn't work properly...Sick sinus syndrome is relatively uncommon, but the risk of developing sick sinus syndrome increases with age. Many people with sick sinus syndrome eventually need a pacemaker to keep the heart in a regular rhythm...Will be free from fast or too slow heart rhythm with use of indwelling pacemaker...Proactive/Preventative Supports and strategies to manage the risk: Cardiologist assesses client routinely and pacemaker checks done via phone usually every 3 months...." Client #3's plans did not include the use of the new heart pacemaker monitoring station located in the facility's dining room.</p> <p>9-3-6(a)</p> <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>			

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	<p>Based on record review, and interview for 4 of 7 clients (clients #1, #2, #6, and #7), the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>On 5/20/14 at 11:20am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 5/1/13 through 5/20/14 were reviewed and indicated the following for client #1, #2, #6, and #7's medication errors.</p> <p>For client #1: -An 10/9/13 BDDS report for an incident on 10/7/13 at 6:30pm, indicated client #1 was given "wrong medication of Clonazepam 0.25mg (milligrams)" for behaviors and was unable to sleep until 10:30pm.</p> <p>For client #2: -A 2/4/14 BDDS report for an incident on 2/1/14 at 6pm, indicated he was given an "extra dose" of Zantac (Ranitidine) 150mg for GERD (stomach upset) medication. -A 1/15/14 BDDS report for an incident on 1/13/14 at 6pm, indicated client #2's "Ranitidine (Zantac) 150mg" for GERD medication was not given.</p>	W000368	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. To ensure medications are given the way as ordered by physician. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have signed physicians orders have the potential to be affected by the same deficient practice all staff will be re trained on medication administration handbook. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Nurse, Manager, QDDP, or CSC will monitor a med. pass daily for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor bi-weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor once a month for one month. If med.</i></p>	06/29/2014	

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	<p>-A 11/19/13 BDDS report for an incident on 11/18/13 at 6pm, indicated client #2 was given an "extra dose" of Ferrous Sulfate (Iron) medication for Anemia.</p> <p>For client #6: -A 6/11/13 BDDS report for an incident on 6/9/13 at 6pm, indicated client #6 was not given his Singular medication for allergies at 6pm.</p> <p>For client #7: -A 12/27/13 BDDS report for an incident on 12/26/13 at 7:30am, indicated client #7's Flomax (tamsulosin hcl) 0.4mg (to relax the bladder) 1 tab 30 minutes after eating breakfast was not given. -A 12/24/13 BDDS report for an incident on 12/24/13 at 7:30am, indicated client #7's Flomax 0.4mg medication was not given 30 minutes after eating.</p> <p>On 5/22/14 at 12:20pm, client #1's 3/2014 "Physician's Order" did not indicate the use of Clonazepam medication.</p> <p>On 5/22/14 at 10:38am, client #2's 3/2014 "Physician's Order" indicated "Ranitidine (Zantac) 150mg 1 tablet twice a day" for GERD (stomach upset) and "Ferrous Sulfate 325mg 1 tablet by mouth twice a day for anemia."</p>		<p>observations show competency of staff passing meds. then the nurse will monitor once every two months. If med. observations show competency of staff passing meds. then the next month the Nurse will monitor quarterly. The Manager and Nurse will follow disciplinary action for failure of staff to follow medication administration protocol as outlined in medication administration handbook along with any retraining and education needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Nurse, Manager, QDDP, or CSC will monitor a med. pass daily for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor bi-weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor once a month</p>				

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	<p>On 5/22/14 at 1pm, client #6's 3/2014 "Physician's Order" indicated "Singular (Montelukast) 10mg 1 tablet daily" for allergies.</p> <p>On 5/22/14 at 1pm, client #7's 3/2014 "Physician's Order" indicated "Flomax (tamsulosin hcl) 0.4mg 1 tablet 30 minutes after eating breakfast."</p> <p>On 5/23/14 at 9:30am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 5/23/14 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p>		<p>for one month. If med. observations show competency of staff passing meds. then the nurse will monitor once every two months. If med. observations show competency of staff passing meds. then the next month the Nurse will monitor quarterly. The Manager and Nurse will follow disciplinary action for failure of staff to follow medication administration protocol as outlined in medication administration handbook along with any retraining and education needed.</p>	

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W000369	<p>On 5/23/14 at 9:30am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION 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, record review, and interview, for 2 of 7 medications administered during the evening medication administration (clients #2 and #7) and 2 of 35 medications administered during the morning medication administration (client #2), the facility failed to ensure medications were given without error.</p> <p>Findings include:</p> <p>1. On 5/20/14 at 4:15pm, Group Home Staff (GHS) #1 asked client #7 to come to the medication room. GHS #1</p>	W000369	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. To ensure medications are given the way as ordered by physician. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have signed physician's orders have the potential to be affected by the same deficient practice all staff will be re trained on medication administration handbook. What measures will be put into place or what systemic changes you will make to ensure</i></p>	06/29/2014			

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	<p>unlocked the medication cabinet, retrieved client #7's medication card of "Lasix 20mg (milligrams), give 1 tab by mouth every other day" for edema (water retention). GHS #1 compared the medication card to client #7's 5/2014 MAR (Medication Administration Record), punched the medication into a souffle cup, administered the medication to client #7, and client #7 took the medication.</p> <p>On 5/22/14 at 1:00pm, client #7's 5/2014 MAR indicated "Furosemide (Lasix) 20mg every other day at 4pm" for water retention. Client #7's MAR indicated his Lasix medication was given on 5/19/2014 at 4pm and Group Home Staff #1 administered again on 5/20/14 at 4pm.</p> <p>On 5/22/14 at 1pm, client #7's 3/2014 "Physician's Order" indicated "Furosemide (Lasix) 20mg every other day at 4pm" for edema (water retention).</p> <p>2. On 5/20/14 at 5:20pm, GHS #2 asked client #2 to come to the medication room. GHS #2 unlocked the medication cabinet, retrieved client #2's medication card of "Omeprazole 20mg 1 tab twice a day for GERD (stomach upset)" take 30 minutes before a meal, and administered client #2 the medication. Client #2 took the medication with water and left the</p>		<p>that the deficient practices does not recur. Nurse, Manager, QDDP, or CSC will monitor a med. pass daily for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor bi-weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor once a month for one month. If med. observations show competency of staff passing meds. then the nurse will monitor once every two months. If med. observations show competency of staff passing meds. then the next month the Nurse will monitor quarterly. The Manager and Nurse will follow disciplinary action for failure of staff to follow medication administration protocol as outlined in medication administration handbook along with any retraining and education needed. How the corrective action(s) will be monitored to ensure the deficient</p>				

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	<p>medication area. At 5:30pm, client #2 consumed his first bite of the supper meal.</p> <p>3. On 5/21/14 at 7:05am, GHS #2 asked client #2 to come to the medication room. GHS #2 unlocked the medication cabinet, retrieved client #2's medication cards of "Omeprazole 20mg 1 tab twice a day for GERD (stomach upset)" take 30 minutes before a meal," "Tylenol Arthritis (Acetaminophen ER) (no tablet dosage documented), 2 tabs once daily for Arthritis," and administered client #2 the unlabeled medication. At 7:13am, client #2 took the medications with water and left the medication area. GHS #2 indicated client #2's Tylenol Arthritis medication did not include documentation on the pharmacy label to determine the milligram measurement for each of the two tablets client #2 received. GHS #2 indicated client #2's Tylenol Arthritis medication label did not match his 5/2014 MAR. At 7:30pm, client #2 consumed his first bite of the breakfast meal.</p> <p>On 5/22/14 at 10:38am, Client #2's 5/2014 MAR (Medication Administration Record) indicated "Omeprazole (Prilosec) 20mg (milligrams) by mouth twice a day for GERD (stomach upset) in applesauce give before a meal with in 30</p>		<p>practice will not recur, i.e., what quality assurance program will be put into place. Nurse, Manager, QDDP, or CSC will monitor a med. pass daily for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor bi-weekly for one month. If med. observations show competency of staff passing meds. then the next month the Nurse, Manager, QDDP, or CSC will monitor once a month for one month. If med. observations show competency of staff passing meds. then the nurse will monitor once every two months. If med. observations show competency of staff passing meds. then the next month the Nurse will monitor quarterly. The Manager and Nurse will follow disciplinary action for failure of staff to follow medication administration protocol as outlined in medication administration handbook along with any retraining and education needed.</p>		

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	<p>minutes before meal)" and "Arthritis Pain Reliever (Tylenol Arthritis) =1300mg daily- 650mg (2 tabs) by mouth daily for Arthritis."</p> <p>On 5/22/14 at 10:38am, client #2's 3/2014 "Physician's Order" indicated "Omeprazole (Prilosec) 20mg (milligrams) 1 cap (capsule) by mouth twice a day for GERD (stomach upset)" and "Acetaminophen ER 650mg, 2 tabs once daily for Arthritis."</p> <p>On 5/23/14 at 9:30am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 5/23/14 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy</p>			

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	<p>and procedure indicated the facility should follow physician orders.</p> <p>On 5/23/14 at 9:30am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The agency nurse stated the facility staff should have administered client #2's Omeprazole medication "at least" 30 minutes before the meal. The agency nurse indicated this was an medication absorption issue for client #2. The agency nurse indicated client #2's Acetaminophen medication was 650mg per tablet and client #2 should have received two tablets to equal 1300mg. The agency nurse stated the staff "should not" have administered a medication in which the label on the medication did not contain the "exact" same information as the MAR and Physician's order. The agency nurse indicated client #2's pharmacy medication label for his Tylenol medication did not include the milligrams for each of the two tablets administered. The agency nurse indicated the staff should have called her to clarify and indicated she had not</p>			

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W000381	<p>received a phone call regarding client #2's medication label not matching the MAR and it was the twenty-third of the month. The agency nurse indicated client #7's Lasix medication was to have been administered every other day. The agency nurse indicated client #7 was given his Lasix in error and the agency nurse stated "this was a significant error."</p> <p>9-3-6(a)</p> <p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on observation, record review, and interview, the facility failed to keep medications locked/secured when not administered for 4 of 4 sampled clients (#1, #2, #3, and #4) and three additional clients (clients #5, #6, and #7) who resided in the home and rode the van.</p> <p>Findings include:</p> <p>On 5/20/14 at 3:30pm, clients #2, #3, #4, #5, #6, and #7 returned home from workshop on the facility van. From 3:30pm until 3:35pm, clients #2, #3, #4, #5, #6, and #7 were assisted into the facility with GHS (Group Home Staff) #1. Client #2's "EpiPen (for bee stings) was in a baggie on the front tote between</p>	W000381	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. To ensure all medications are being stored and being transported safely and by protocol as outlined in medication administration handbook. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have medications and who take medications at various times that need be given not only at home but when out of facility. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does</i></p>	06/26/2014

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	<p>the seats of the van. At 4:30pm, GHS #1 showed the surveyor the facility van where client #2's medication was stored each day during transport. GHS #1 indicated she kept the van locked but had transported client #2's medication inside the unlocked tote daily when the van picked up clients #1, #3, #5, and #7 at workshop #1 and clients #2, #4, and #6 at workshop #2. GHS #1 indicated clients were picked up and dropped off at both workshops twice a day leaving client #2's medication inside the van with other clients each time.</p> <p>On 5/22/14 at 3:25pm, at workshop #2 the facility van arrived from workshop #1 with clients #1, #5, and #7 on the van to pick up clients #2, #3, #4, and #6 at the agency/workshop #2. At 3:25pm, the workshop supervisor pulled out client #2's EpiPen medication inside a baggie and handed it to GHS #1. Workshop supervisor stated the staff who dropped client #2 off at the workshop this morning "forgot" the medication and when the staff at the workshop located it the workshop supervisor locked the medication up. GHS #1 took client #2's EpiPen medication, walked to the facility van, and placed the medication on the dash of the vehicle. At 3:27pm, GHS #1, GHS #3, clients #1, #2, #3, #4, #5, #6, and #7 left on the facility van.</p>		<p><i>not recur. Supervisor will monitor regularly on a weekly basis and Nurse will monitor monthly. Supervisor and Nurse will follow disciplinary action for failure of staff not following proper storage and transporting of medications as outlined in medication administration handbook along with any retraining and education needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Supervisor will monitor regularly on a weekly basis and Nurse will monitor monthly.</i></p>	

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(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			
	<p>On 5/23/14 at 9:30am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff" indicated "Transporting Medications/Off Site Use: Medications may be transported without being in a locked container if they do not leave the staff person's possession...For outings by residential or day service staff, all medications should be in a locked container."</p> <p>On 5/23/14 at 9:30am, an interview with the agency nurse was conducted. The agency nurse indicated medications should be kept locked/secured when medications were not administered. The agency nurse indicated the facility followed "Living in the Community" for medication administration. The agency nurse indicated the agency policy indicated client #2's EpiPen medication should have been kept secured or in a locked container.</p> <p>On 5/22/14 at 9:30am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication should be kept secure when not administered.</p>						

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W000388	<p>9-3-6(a)</p> <p>483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, for 1 of 42 medications administered (client #2), the facility failed to ensure client #2's medication label contained dosage measurement information amounts for each tablet dispensed by the pharmacy.</p> <p>Findings include:</p> <p>On 5/21/14 at 7:05am, GHS #2 requested client #2 to come to the medication room, GHS #2 unlocked the medication cabinet, retrieved client #2's medication card "Tylenol Arthritis (Acetaminophen ER) (no medication dosage measurement documented), 2 tabs once daily for Arthritis," two tablets were encapsulated in the card container, and GHS #2 administered client #2 the medication.</p> <p>On 5/22/14 at 10:38am, Client #2's 5/2014 MAR (Medication Administration Record) indicated "Arthritis Pain Reliever (Tylenol Arthritis) =1300mg daily- 650mg (2 tabs) by mouth daily for</p>	W000388	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>To ensure all medications labels match what is on MAR and Physicians orders.</p> <p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All clients who have signed physician's orders have the potential to be affected by the same deficient practice all staff will be re trained on medication administration handbook.</p> <p><i>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.</i></p> <p>Nurse will monitor med pass quarterly and supervisor and nurse will follow disciplinary action for failure of staff not following medication administration protocol as outlined in medication administration handbook along with any</p>	06/26/2014

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	<p>Arthritis."</p> <p>On 5/22/14 at 10:38am, client #2's 3/2014 "Physician's Order" indicated "Acetaminophen ER 650mg, 2 tabs once daily for Arthritis."</p> <p>On 5/23/14 at 9:30am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff" indicated "Never administer a medication from an unlabeled or illegibly labeled container. Notify the nurse if there is a label concern...Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...Check the medication listed on the medication administration record with the medication label three times...."</p> <p>On 5/23/14 at 9:30am, the 2004 "Core A/Core B Medication Training" indicated "Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled. The training manual indicated each clients' medication should be dated when the medication was opened. "Lesson 3 Principles of Administering Medications." The Core A/Core B policy</p>		<p>retraining and education needed.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i></p> <p>Nurse will monitor med pass quarterly</p>				

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	<p>and procedure indicated the facility should have a label with the name, medication ordered, dosage, and site of instillation.</p> <p>On 5/23/14 at 9:30am, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated client #2's Acetaminophen medication was 650mg per tablet and client #2 should have received two tablets to equal 1300mg. The agency nurse stated the staff "should not" have administered a medication in which the label on the medication did not contain the "exact" same information as the MAR and Physician's order. The agency nurse indicated the staff should have called her to clarify and indicated she had not received a phone call regarding client #2's medication label not matching the MAR and it was the twenty-third of the month.</p> <p>9-3-6(a)</p>			