

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G460 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>11/10/2011 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>DUNGARVIN INDIANA LLC |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>55693 ASH RD<br>OSCEOLA, IN46561   |                      |   |
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| W0000   | <p>This visit was for a post certification revisit (PCR) to the annual recertification and state licensure survey completed 09/08/2011.</p> <p>Dates of Survey: November 9 and 10, 2011.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>Provider Number: 15G460<br/>Facility Number: 000974<br/>AIM Number: 100244830</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.<br/>Quality Review completed 11/22/11 by Ruth Shackelford, Medical Surveyor III.</p> | W0000   |   |                      |   |
| W0369   | <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p>  | W0369   | <p>The staff person responsible for the medication error has been retrained on the specific concerns noted in the survey report. The physicians order sheets have been reviewed also and corrected to match the time that</p> | 11/29/2011           |   |

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>Based on observation, record review, and interview, the facility failed to ensure medications were administered without error for 2 of 10 medication doses administered during the evening medication pass (clients #2 and #6).</p> <p>Findings include:</p> <p>On 11/9/11 at 5:04pm, client #2 was requested to come to the medication room by DCS (Direct Care Staff) #1. At 5:04pm, DCS #1 assembled client #2's medication from a medication card which indicated "Geodon 20mg (milligrams) capsule, give 1 capsule orally daily at bedtime with food." At 5:10pm, DCS #1 gave the medication to client #2, client #2 took the medication with water, and left the medication room. At 5:10pm, client</p> |   | <p>medications are being administered. All staff at the home has reviewed this standard as well. The Program Director, facility nurse, and designee's will conduct random medication passing observations at the home with various staff to ensure consistency in the medication passing system. All ICF Program Directors will review this standard and assure that this issue is being evaluated as a possible concern in all ICF-MR's.</p> <p><b>Persons Responsible: Program Director /QMRP, Facility Nurse</b></p> |                      |   |

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|   | <p>#2's 10/20/11 "Physician's Order" was reviewed and indicated "Geodon 20mg (milligrams) capsule, give 1 capsule orally daily at bedtime with food." At 5:10pm, client #2's 11/2011 MAR (Medication Administration Record) was reviewed and indicated "Geodon 20mg (milligrams) capsule, give 1 capsule orally daily at 5pm." At 5:10pm, client #2 stated "I go to bed at 8pm, it (the medication) makes me go to sleep faster."</p> <p>On 11/9/11 at 5:37pm, client #6 was requested to come to the medication room by DCS #1. At 5:37pm, DCS #1 assembled client #6's medication from a medication card which indicated "Risperidone 3mg tablet, give 1 tablet orally at bedtime." At 5:40pm, DCS #1 gave the medication to client #6, client #6 took the medication with water, and left the medication room. At 5:40pm, client #6's 4/8/11 "Physician's Order" was reviewed and indicated "Risperidone 3mg tablet, give 1 tablet orally at bedtime." At 5:40pm, client #6's 11/2011 MAR indicated "Risperidone 3mg tablet, give 1 tablet orally at 5pm."</p> <p>On 11/9/11 at 1:05pm, the agency LPN (Licensed Practical Nurse) indicated the facility followed Core A/Core B policy and procedures for administering medications.</p> |   |   |   |  |   |  |

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|   | <p>On 11/9/11 at 1:05pm, the facility's 4/2011 policy and procedure "Policy and Procedure on Medication Administration" indicated "All medications dispensed will be administered in a safe manner consistent with state and federal regulations...E. When preparing medications for administration, the labels will be checked against the Medication Administration Record to ensure that the prescription label corresponds to the order...."</p> <p>On 11/10/11 at 10am, an interview with the Site Director (SD) and the QDDP (Qualified Developmental Disability Professional) was completed. The SD and the QDDP both indicated the facility staff should have followed physician's orders for each medication. The SD and QDDP both indicated client #2 and #6's medications were given in error when each client's physician order was not followed. The SD and QDDP both stated the agency nurse told them the staff did not follow client #2 and #6's physician orders for the medications to have been given "at bedtime."</p> <p>On 11/10/11 at 10:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core</p> |   |   |                      |   |

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| W0382   | <p>Lesson 3: Principles of Administering Medication" indicated staff should follow physician's orders when administering medications.</p> <p>This deficiency was cited on 9/8/2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> | W0382   | <p>All direct care staff at the site will be retrained on the medication passing guidelines, which include ensuring that all drugs and biologicals are locked except during times of preparation for administration. Retraining and disciplinary action has been completed with the staff observed to not follow this practice. Observations during med-passing times will be completed by the Program Director/ QMRP, facility nurse, or other designee. Immediate feedback is given during these observations for any concerns noted. Medication errors including concerns of violations to the standard of ensuring all drugs and biologicals are to be locked except during times of preparation for administration will be handled through retraining and disciplinary action according the Dungarvin policy and procedure on Medication</p> | 11/29/2011           |   |

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|   | <p>Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>On 11/9/11 from 3:45pm until 6:12pm, observation and interview were completed at the group home. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed independently walking throughout the group home including the medication/office room. From 5:04pm until 6:05pm, medication administration was completed by DCS (Direct Care Staff) #1 and the medication cabinet keys hung in the lock to the cabinet. From 5:04pm until 5:15pm, DCS #1 assembled client #2's medication, administered her medication, and left the medication room to retrieve the telephone in the dining room outside of view. From 5:15pm until 5:25pm, client #2 sat inside the medication room, the medication cabinet</p> |   | <p>Administration.<br/>System wide, all Program Director/QMRPs and nurses will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.<br/><b>Persons Responsible: Program Director/ QMRP, Facility Nurse</b></p> |                      |   |

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|   | <p>was unlocked, and the keys hung in the lock. At 5:35pm, client #6 walked into the medication room, client #2 and DCS #1 left the medication room, the medication cabinet was unlocked and the keys hung in the lock to the medication cabinet. At 5:37pm, DCS #1 returned to the medication room, relocked the medication cabinet, then unlocked the medication cabinet. When asked "Was the cabinet unlocked?" DCS #1 responded "I locked it then unlocked it." At 5:45pm, DCS #1 left the medication room and left the keys dangling from the lock in the cabinet. At 5:45pm, DCS #1 administered client #4's medication. At 5:50pm, DCS #1 left the medication room with client #4 and left the keys dangling from the medication cabinet lock. At 5:50pm, DCS #1 administered client #5's medication. At 5:55pm, DCS #1 left the medication room and left the keys dangling from the medication cabinet lock. At 6:05pm, DCS #1 stated "keys can be in the lock" as long as medications were being administered. DCS #1 indicated the medications inside the medication room were not secure when the medication cabinet was left unlocked.</p> <p>On 11/9/11 at 1:05pm, the agency LPN (Licensed Practical Nurse) indicated the facility followed Core A/Core B policy and procedures for administering</p> |   |   |                      |   |

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|   | <p>medications.</p> <p>On 11/9/11 at 1:05pm, the facility's 4/2011 policy and procedure "Policy and Procedure on Medication Administration" indicated medications should have been secured except when administered.</p> <p>On 11/10/11 at 10am, an interview with the Site Director (SD) and the QDDP (Qualified Developmental Disability Professional) was completed. The SD and the QDDP both indicated the facility staff should have secured the medications in the group home and the keys should not have been left dangling from the lock.</p> <p>On 11/10/11 at 10:30am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should be kept secured.</p> <p>This deficiency was cited on 9/8/2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> |   |   |                      |   |