

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G266	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2016
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 642 BELMONT DRIVE EVANSVILLE, IN 47711
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W 0000 Bldg. 00	<p>This visit was for a full recertification and state licensure survey. This visit included the investigations of Complaint #IN00189042 and Complaint #IN00191533.</p> <p>Complaint #IN00189042: Substantiated, no deficiencies related to the allegation(s) were cited.</p> <p>Complaint #IN00191533: Substantiated, no deficiencies related to the allegation(s) were cited.</p> <p>Dates of Survey: 2/18, 2/19, 2/22, 2/23, 2/24 and 2/25/16.</p> <p>Facility Number: 000786 Provider Number: 15G266 AIM Number: 100248990</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/8/16.</p>	W 0000		

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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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 1 of 4 sampled clients (B), the facility failed to develop and implement written policies and procedures that prohibit mistreatment, abuse and/or neglect in regard to client B receiving another client's medication and causing a subsequent hospitalization.</p> <p>Findings include:</p> <p>The facility's internal reports, BDDS (Bureau of Development Disabilities Services) Reportables and Investigations were reviewed on 2/18/16 at 2:45 PM.</p> <p>--A BDDS reportable dated 12/30/15 indicated "it was reported that staff noticed that [client B] was appearing to be pale. Staff took her blood pressure and it was low. They also took her temperature and it was also low. Staff</p>	W 0149	<p>W149 Staff in question was suspended from passing medications from 1/4/16 to 1/6/16. The staff in question received corrective action and retraining on 1/6/16. The nurse did a med pass observation/ medication administration skills checklist with this same staff on 1/6/16 to ensure she passed meds correctly. On 12/31/15, the staff in the home received Medication Administration and Medication Storage training from the Program Coordinator. Nurse or management staff will do random medication observations/ medication administration skills checklist with random staff at least 2 to 3 times a week for four weeks, then at least 1 to 2 times a week for four weeks to ensure that staff are administering medications correctly. The Nurse or management staff will continue to do informal observations on a monthly basis to ensure staff continue to administer medications correctly. Should</p>	03/26/2016

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	<p>stated that [client B] was not talking and that this was abnormal for her. The nurse and program Director were contacted and staff were directed to take [client B] to the ER (Emergency Room). Staff to (sic) [client B] to the ER and the ER staff ran tests on her. It was reported that all the tests showed as normal and [client B] was sent home. Staff directed by the Nurse to closely observe [client B] through the night. Staff will continue to monitor [client B] and will follow up with the doctor if needed."</p> <p>--A BDDS reportable dated 12/31/15 indicated "It was reported that [client B] was continuing to have issues after going to the ER on 12/30/15 and her tests showing (sic) all to be normal. She continued to be pale, had a low grade fever and had a high pules (sic). The team decided to take her to the ER again. The ER staff ran tests again and all showed normal besides her heart rate being high. They gave her some valium to attempt to calm her down and were unable to determine the exact cause of the issues. The ER staff decided to admit [client B] because her heart rate would not go down."</p> <p>--A BDDS reportable dated 1/4/16 indicated "This Program Director received [client B's] discharge paperwork</p>		<p>staff continue to make medication errors, management will proceed with further training and corrective action as needed for individual staff. No other clients were affected by this deficient practice. Responsible parties: Nurse, Program Director, Program Coordinator and Direct Support Professionals</p>	

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	<p>on 1/4/16 from her hospital stay. The hospital was having a hard time determining what was going on with [client B's] condition and at some point during her stay staff asked the hospitalist if it was possible that (her condition) was a result receiving the wrong medication. The hospital was unable to determine any other issues during her hospital stay and they are not stating that her condition was due to a medication error. The statement from the staff and the statement from the hospital is purely speculation that [client B's] condition at the time could be the result of being given the wrong medication. [Client B] has been discharged from the hospital and appears to be in normal health. An investigation was started 1/4/16 to determine whether or not a medication error occurred around the time [client B] was admitted to the hospital."</p> <p>--A Summary of Internal Investigation Report dated 1/7/16 indicated "brief summary of the incident: When [client B] was discharged from the hospital on 1/4/16, after being there for having issues with her heart rate and being pale, the hospital staff stated on the discharge paperwork that it was possible that [client B's] issues were caused by receiving the wrong medication. Factual findings:</p>			

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	<p>--[Name of the group home manager] was interviewed by [Name of Program Manager]: [Name of the group home manager] reported that on 1/4/16 [client B's] discharge paperwork came to the office and that in it was stated (sic) that [client B's] issues were possibly caused by receiving the wrong medication. [Name of group home manager] stated that on 12/31/15 [staff #2] came to her and reported that she believed that she gave [client B] another client's medication on 12/30/15. [Staff #1] thought that she gave [client B] [client C's] medication which included extra Oxcarbazepine (anticonvulsant drug primarily used to treat seizures), Topiramate (anticonvulsant drug) and Invega (used to treatment of schizophrenia). [Name of group home manager] discussed that on 12/30 [client B] was taken to the ER because she appeared to be pale, she was not talking and her blood pressure was low. [Name of group home manager] said that the tests at the ER all showed as normal. [Name of group home manager] reported that on 12/31 while [client B] was at the day program she continued to appear pale and her pulse was high. [Name of group home manager] stated that the team (IDT - Interdisciplinary Team) agreed that the ER should be made aware of the possibility of [client B] receiving the</p>			

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	<p>wrong medication. [Name of the group home manager] said that the doctor told her that it was possible that [client B's] issues were caused by receiving the wrong medication. [Name of the group home manager] reported that [client B] was admitted to the hospital on 12/31 because the hospital could not get her heart rate to go down and kept her until 1/2/16. [Name of group home manager] reported that possible med error to [Name of Program Director] and the nurse and an investigation was started. After meeting and discussing [client B's] condition at the time, the nurse, [Name of group home manager] and [Name of program director] agreed that [client B] should be taken to the ER again."</p> <p>--"[Staff #1] was interviewed by [Name of program director]: [Staff #1] stated that when she was giving [client C] her medicine on 12/30 when she noticed a blue pill in the client's cup that she did not remember that client having. The medication packs have descriptions of the pills on them. [Staff #1] appears to have given [client C] [client B's] medicine and [client B] [client C's] medicine. The two clients were given each other's medications."</p> <p>"Conclusion: It appears that [staff #1] gave [client B] and [client C] the wrong medications on 12/30/15."</p>			

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	<p>--A BDDS incident follow up report dated 1/8/16 indicated "[client B] appears back to normal health. Normal range of her vitals are 119mmHG (millimeter of mercury) /79 mm HG. Staff are trained on maintaining vitals and reporting to the nurse."</p> <p>--A BDDS incident follow up report dated 1/25/16 indicated "The investigation resulted in proving that staff did give [client B] the wrong medication. She has appeared to recover well and is not displaying any negative affects from the medication. No updates are needed to her risk plans. Staff received corrective action and re-training."</p> <p>Review of client B's 2/1-2/29/16 physician's order on 2/23/16 at 11:50 AM indicated client B did not take Oxcarbazepine, Topiramate or Invega.</p> <p>Interview with the group home nurse was completed on 2/25/16 at 1:50 PM. She stated "[Client B] was taken to the ER on 12/30 for evaluation after it was discovered that she had been given another client's medications. Her lab work was normal and she was discharged back to the group home. The following day (12/31/15), she began displaying the same signs and symptoms of appearing to</p>			

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	<p>be pale, increased heart rate and 'not herself', she was taken back to the ER and because they couldn't get her heart rate down, she was admitted until 2/2/16. The staff said the doctor indicated her issues were caused by receiving [client C's] medications."</p> <p>The undated Operating Practices - Supervised Group Living Services was reviewed on 2/25/16 at 9:05 AM and indicated "Any instances of abuse, neglect, exploitation, or violation of rights will be communicated to the appropriate local authorities, the legal representative, the administrator, identified as the Area Director for this purpose, and emergency contact designated by the individual in the ISP (Individual Support Plan). Any time an individual has been the victim of abuse, neglect, or exploitation or mistreatment, steps will be taken immediately to protect the individual from further abuse, neglect, exploitation or mistreatment. [Name of Facility] programs maintain a written list of rights, which taken into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment."</p>			

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W 0331 Bldg. 00	<p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 4 additional clients (E), the facility's nursing services failed to ensure the client's blood pressure was taken according to the physician's orders.</p> <p>Findings include:</p> <p>During the morning medication pass on 2/19/16 at 6:40 AM, client E received the</p>	W 0331	W331 The Staff in question received corrective action on 3/15/16. On 3/4/16, all staff were retrained on medication administration, buddy checks and following physicians orders during medication administration. Nurse or management staff will do random medication observations/ medication administration skills checklist with random staff at least 2 to 3 times a week for four weeks, then at least 1 to 2 times a week for four weeks to ensure	03/26/2016

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W 0368 Bldg. 00	<p>following medications from staff #4: Ascorbic Acid 1000 mg (milligrams) (supplement), Oxcarbazepine 600 mg (seizures), Topiramate 100 mg (seizures) , Vitamin D3 1000 units, and Chlorhexadine 0.12 % mouth wash. Staff #4 did not take client E's blood pressure.</p> <p>Client E's 2/1-2/29/16 physician's order was reviewed on 2/23/16 at 11:00 AM. The physician's order indicated client E was to have his blood pressure taken every morning at 7:00 AM.</p> <p>The facility nurse was interviewed on 2/23/16 at 11:20 AM. She stated "sometimes the staff takes [client E's] blood pressure during the 4 PM medication pass. Staff should be taking the blood pressure at 7:00 AM as indicated on the physician's order. I will need to do retraining with all staff here at the group home to make sure it is done at the correct time (7AM)."</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must</p>		that staff are administering medications correctly. The Nurse or management staff will continue to do informal observations on a monthly basis to ensure staff continue to administer medications correctly. Should staff continue to make medication errors, management will proceed with further training and corrective action as needed for individual staff. No other clients were affected by this deficient practice. Responsible parties: Nurse, Program Director, Program Coordinator and Direct Support Professionals		

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	<p>assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview for 1 of 4 additional clients (G), the facility failed to assure that all drugs are administered in compliance with the physician's order in regards to client G receiving another client's medication.</p> <p>Findings include:</p> <p>During review of the facility's incident reports, BDDS (Bureau of Developmental Disabilities Services) reportables and investigations on 2/18/16 at 2:45 PM, a BDDS report dated 1/18/16 indicated "it was reported that [client G] walked into the medicine room during medication pass time because he was on a call with his mother and instructed by her to take an item to the staff. The staff were (sic) in the middle of passing medication to another client when [client G] walked in unannounced. [Client G] then took it upon himself to pick up and take the medicine that was set up for the another (sic) client before the staff could stop him. As a precaution the nurse had [client G] taken to the ER (Emergency Room) for evaluation because one of the meds can lower blood pressure. [Client G] checked out as normal at the ER with no follow up required as this was not a</p>	W 0368	W368 The staff in question received corrective action on 1/29/16. Staff received training on 1/27/16 at the scheduled staff meeting on locking the med room door during medication administration so that only the staff passing medications and the client receiving medications are in the room during medication administration times. All staff received retraining on medication administration and buddy checks on 2/2/16 as well. Nurse or management staff will do random medication observations/ medication administration skills checklist with random staff at least 2 to 3 times a week for four weeks, then at least 1 to 2 times a week for four weeks to ensure that staff are administering medications correctly. The Nurse or management staff will continue to do informal observations on a monthly basis to ensure staff continue to administer medications correctly. Should staff continue to make medication errors, management will proceed with further training and corrective action as needed for individual staff. No other clients were affected by this deficient practice. Responsible parties: Nurse, Program Director, Program Coordinator and Direct Support Professionals	03/26/2016			

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	<p>life threatening medication error. An investigation will be conducted to determine if staff is in need of corrective action. Staff will be retrained on client privacy and securing medicine during a med pass. The nurse, Program Coordinator and Program Manager will meet to discuss forming another set up for medication pass to ensure client privacy during med pass and staff will be retrained on the new set up. [Client G] will also receive training regarding not walking in during med pass and not picking up and taking pills that are not administered to him by staff." An Investigative Summary dated 1/19/16 indicated "[staff #5] was interviewed by the [Name of Program Manager] and stated that she was in the med room giving [client F] her meds. [Staff #5] reported that [Name of the home manager] came into the room for something. [Staff #5] stated that [client F] and she (sic) walked over to the desk and she left the meds on the counter. [Staff #5] stated that when she looked at [client G] he was standing in the room holding the empty med cup. [Staff #5] stated that they notified the nurse and Program Coordinator. [Staff #5] reported that [Name of Program Coordinator] took [client G] to the ER to be checked out." The conclusion of the investigative summary indicated "[Staff #5] will</p>			

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	<p>receive corrective action and retraining. All staff and clients should review not entering the med room during med passes to limit the risk of medication errors."</p> <p>Interview with the Facility Nurse was completed on 2/23/16 at 10:20 AM. She stated "[client G] came into the med room with the telephone saying his mother had a question and before [staff #5] could stop him, he had already taken [client F's] medications. Staff have been retrained to make sure the door to the med room is closed and to be more cognizant of clients entering the room. [Client G] has been retrained on making sure to afford other clients privacy during their med passes."</p> <p>Electronic interview with the Program Director on 2/24/16 at 4:07 PM indicated client G received Clonidine 0.1 mg (milligram) (hypertension) and Topamax 200 mg (seizures) which belonged to client F.</p> <p>9-3-6(a)</p>				