

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G801	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/04/2012
NAME OF PROVIDER OR SUPPLIER ADEC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6712 MACKEY CT SOUTH BEND, IN 46614		
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W0000	<p>This visit was an extended recertification and state licensure survey.</p> <p>Dates of Survey: March 28, 29, April 1, 2, 3, 4, 2012.</p> <p>Facility number: 012599 Provider number: 15G801 AIM number: 2010123260</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/11/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0192	<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 record review, interview and observation, the facility failed for 7 of 7 clients who received medications (clients #1, #2, #3, #4 #5, #6, #7), to ensure staff were trained to administer medications without error.</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 3/28/12 at 4:20 PM and included the following:</p> <p>For client #1:</p> <ul style="list-style-type: none"> - A report dated 6/22/11 indicated client #1 did not received his complete dose of Depakote (mood instability) on the evening of 6/22/11. -A report dated 6/7/11 indicated client #1 did not receive his complete dosage of Depakote 125 mg (milligrams) capsules. -A report dated 9/22/11 indicated client #1 did not get his complete dosage of Divalproex 125 mg. He should have received 4 pills, but only received two. 	W0192	<p>On 4/6/12 all facility staff were trained by the facility nurse on medication administration. They were again trained on 4/17/12 given the same information. Not all individuals in the home have templates, it is up to administration as to when to begin them and it is often after a medication error that had been repeated. This may be the reason why this information was not seen during the observations. In order to prevent this in the future, the manager and QDDP will conduct medication check off forms two times per week to ensure compliance.Failure to comply will result in disciplinary action.Person Responsible: QDDP</p>	04/18/2012			

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	<p>For client #2:</p> <p>-A report dated 9/8/11 indicated client #2 did not receive his 3 PM dosage of Dilantin 100 mg capsule (seizures).</p> <p>For client #3:</p> <p>-A report dated 2/7/12 indicated client #3 did not receive his complete dosage of Carbamazepine (mood stability) at 9:00 PM.</p> <p>-A report dated 7/18/11 indicated client #3 did not receive the correct dosage of his bedtime medication on 7/17/11. He received one, not three pills of Carbamazepine 200 mg and received one, not three Risperidone. 25 mg pills. The medications Risperdone and Tegretol are psychoactive medications.</p> <p>For client #4:</p> <p>-A report dated 5/13/11 indicated client #4 did not receive his am dosage of Bactrim DS 800/160 mg. Client #4 was to receive Bactrim for 7 days (antibiotic).</p> <p>-A report dated 4/12/11 indicated on 4/13/11 at 5:00 PM, client #4 did not get his entire dose of Lamictal (seizures).</p> <p>-A report dated 11/20/11 indicated client</p>				

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	<p>#4 didn't receive Omeprazole for GERD (gastroesophageal reflux disease).</p> <p>-A report dated 2/3/12 indicated client #4 didn't receive his complete dosage of Lamotrigine (seizures) 150 mg. He should have received two pills and received only one.</p> <p>-A report dated 10/6/11 indicated client #4 did not receive his complete dose of Oxcarbazepine 300 mg. He should have received two pills, but only received one.</p> <p>-A report dated 10/9/11 indicated client #4 did not receive his complete dose of Oxcarbazepine 300 mg. He should have received two pills, but only received one.</p> <p>-A report dated 9/21/11 indicated client #4 did not receive his complete dose of Oxcarbazepine 300 mg (seizures). He should have received two pills, but only received one.</p> <p>-A report dated 7/30/11 indicated client #4 did not receive his complete dosage of Lamotrigine 150 mg pills. He should have received two pills, but only received one.</p> <p>-A report dated 5/20/11 indicated client #4 did not receive his 1 AM dose of the antibiotic Clindamycin HCL</p>				

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	<p>(hydrochloride)/50 50 mg.</p> <p>For client #5:</p> <p>-A report dated 1/10/12 indicated client #5 didn't receive a complete dose of Seroquel 400 mg (mood instability). He should have received two pills, but only received one.</p> <p>-A report dated 1/7/12 indicated on 1/6/12 at 5:00 PM client #5 didn't receive his complete dosage of Depakote 125 mg sprinkles (mood instability). He should have received 8 capsules, but only received 4.</p> <p>-A report dated 8/18/11 indicated on 8/17/11 client #5 did not receive his complete dosage of Depakote. He should have received 3 pills, but only received one.</p> <p>-A report dated 6/21/11 indicated client #5 did not receive his full dose of Depakote on 6/20/11. He should have received three 500 mg pills, but only received one.</p> <p>-A report dated 5/14/11 indicated client #5 did not receive his complete dosage of Depakote. He should have received 3 pills, but only received one.</p>						

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	<p>-A report dated 5/12/11 indicated client #5 did not receive his complete dose of Vimpat 100 mg on 5/12/11. He should have received two pills, but only received one.</p> <p>-A report dated 4/12/11 indicated client #5 only received half his dosage of Depakote.</p> <p>For client #6:</p> <p>-A report dated 2/4/12 indicated client #6 did not receive his complete dosage of Depakote 125 mg (mood stability). He should have received 5 pills, but only received one.</p> <p>-A report dated 2/3/12 indicated client #6 didn't receive his 8:00 PM dose of Ativan .5 mg (mood instability).</p> <p>-A report dated 12/27/11 indicated client #6 did not receive Depakote 125 mg sprinkles. He should have received 4 capsules, but did not receive any.</p> <p>For client #7:</p> <p>- A report dated 12/25/11 indicated client #7 did not receive his Metformin 500 mg at 7:00 AM on 12/25/11.</p> <p>-A report dated 10/10/11 indicated client</p>						

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	<p>#7 did not receive his complete dosage of Metformin (diabetes). He should have received two pills, but only received one.</p> <p>The reports indicated staff would receive appropriate training and discipline for the medication administration errors.</p> <p>During the medication administration pass on 3/29/12 beginning at 6:55 AM, clients #4 and #6 received their medications from staff #10. Staff #10 reviewed the pill label and the medication administration record to determine which medications to administer to clients #4 and #6. There were no other aids used to determine which medications to administer.</p> <p>The house manager was interviewed on 3/29/12 at 8:07 AM and indicated medication errors had been addressed by implementing a template system for staff to use during medication administration, and another staff was to "buddy check" the medications to be passed to reduce errors by checking for accuracy.</p> <p>Staff #10 was interviewed on 3/29/12 at 8:10 AM and indicated the use of the template was for new staff to ensure medications were administered without error.</p>			

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	The QMRP and nurse were interviewed on 4/4/12 at 12:20 PM and indicated the template was to be used to prevent medication errors in the home. 9-3-3(a)				

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services is not met. The facility failed to provide adequate health care monitoring and nursing services for 1 of 1 deceased clients (client #8).</p> <p>Findings include:</p> <p>1. Please refer to W331. The facility failed to provide adequate health care and nursing services for 1 of 1 deceased clients (client #8).</p> <p>2. Please refer to W368. The facility failed for 7 of 7 clients who received medications (clients #1, #2, #3, #4 #5, #6, #7), to administer medications per physician's orders.</p> <p>9-3-6(a)</p>	W0318	<p>On 4/6/12 all facility staff were trained by the facility nurse on medication administration. They were again trained on 4/17/12 given the same information. Not all individuals in the home have templates, it is up to administration as to when to begin them and it is often after a medication error that had been repeated. This may be the reason why this information was not seen during the observations. In order to prevent this in the future, the manager and QDDP will conduct medication check off forms two times per week to ensure compliance. Failure to comply will result in disciplinary action. Person Responsible: QDDP/All BDDS reports were available to the surveyor when asked. The entire packet that was sent to the MRC was also available. It is appropriate to note that on 4/17 12 documentation was sent from the MRC on the individuals death, and the following was stated, " The MRC appreciates the information you provided. This information is used to ID trends, training needs, and make recommendations for systemic improvement.s.The MRC did not make any recommendations or referrals to other entities. The case is closed." All facility nurses have been trained on following</p>	04/18/2012	

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			health support plans and seeking prompt medical attention when an individual is in need. Failure to respond to this corrective action will result in disciplinary action. Person Responsible: Health Care Coordinator		

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to provide timely health care and nursing services for 1 of 1 deceased client (client #8).</p> <p>Findings include:</p> <p>The facility's incident reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/28/12 at 3:28 PM and did not include a report of a death in the group home.</p> <p>Observations were completed at the group home on 3/28/12 from 5:05 PM to 6:12 PM. There was an empty bed in one of the bedrooms and the house manager indicated it had been occupied by client #8 who had died in January, 2012.</p> <p>BDDS reports regarding client #8 were reviewed on 3/29/12 at 10:45 AM. A report dated 1/1/12 indicated client #8 had been transported to the hospital, evaluated for a fever of 104 degrees and general breathing trouble per the agency nurse and the client's asthma risk plan. He was diagnosed with pneumonia and admitted to the ICU (intensive care unit). A report dated 1/4/12 indicated client #8 had</p>	W0331	<p>All BDDS reports were available to the surveyor when asked. The entire packet that was sent to the MRC was also available. It is appropriate to note that on 4/17 12 documentation was sent from the MRC on the individuals death, and the following was stated, " The MRC appreciates the information you provided. This information is used to ID trends, training needs, and make recommendations for systemic improvement.s.The MRC did not make any recommendations or referrals to other entities. The case is closed." All facility nurses have been trained on following health support plans and seeking prompt medical attention when an individual is in need. Failure to respond to this corrective action will result in disciplinary action.Person Responsible: Health Care Coordinator</p>	04/18/2012			

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	<p>passed away while in the hospital at 5:45 PM.</p> <p>The facility's review of client #8's death was reviewed on 3/29/12 at 11:36 AM. A Health Care Support Plan dated 12/2/11 indicated client #8 was "At High Risk for pneumonia d/t (due to weakened lungs)." The plan indicated client #8's PCP (primary care physician) was to be notified if client #8 developed a cough or fever. Staff were to monitor for s/s (signs and symptoms) of pneumonia and if any are noted to notify the PCP. Signs and symptoms to be monitored included fever and cough. A death certificate dated 1/6/12 indicated client #8's cause of death was "bacterial pneumonia." The history and physical exam from the hospital on 1/1/12 indicated client #8 had "two or three admissions to [hospital name] over the last two years for severe pneumonia." Client #8's temperature in the emergency room was 100.5 and the chest x-ray showed right side pneumonia.</p> <p>"Impression: 1. Bacterial pneumonia with sepsis syndrome. 2. Down's syndrome, profound mental handicap. 3. Prior history of aspiration pneumonia...."</p> <p>Consultation dated 1/1/12 indicated, "He has a longstanding history of dysphagia... He has been admitted at least four times at [hospital name] and at least 1 time to [another hospital name]. The patient's</p>			

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	<p>presentation is very typical of his previous hospitalizations...The patient was admitted and found to be in shock and is now in the intensive care unit...Assessment and Plan: Recurrent pneumonia related to aspiration related to Down's Syndrome. His respiratory illness and critical illness at this point is clearly a manifestation of his impaired neurological status...His overall prognosis is exceedingly poor...." The ER (emergency room) Physician's report dated 1/1/12 indicated Diagnostic Impression: Septic shock and pneumonia...Disposition: Inpatient, critical..." The records indicated client #8 continued to deteriorate in the hospital, was removed from life support and died on 1/4/12. Quarterly progress/Nurses Notes dated 1/1/12 and signed by LPN (Licensed Practical Nurse) #2 indicated at 1:11 AM she had received a phone call from "beeper that stated [group home] had called and was concerned about [client #8] that he had a temp (temperature) of 104. I told beeper to have them give him Tylenol to see if that helps and if it doesn't to let me know. I then received another call at 3:13 AM from beeper that staff was concerned about his breathing. I went to the house and assessed him. He was resting in bed and I could hear his congestion without using a stethoscope and I checked his</p>						

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	<p>bioX (oxygen level reading) and it read in the lower 70's. I determined that he needed to go to ER to be evaluated. I assisted [staff] and we got him dressed and transferred him to her car and she left to go to the ER." Client #8's ISP dated 5/12/11 indicated "His lung health is still an on-going issue that is evaluated and monitored by his PCP, [Doctor name]. Staff will continue to monitor his health closely to ensure he is not getting ill due to the recent past of becoming seriously ill very quickly. Staff will report any abnormal behavior, fatigue or trouble breathing to nurse and follow up with his PCP...."</p> <p>LPN #1 was interviewed on 3/29/12 at 12:15 PM. She indicated client #8 had a history of being ill with pneumonia rapidly.</p> <p>LPN #2 was interviewed on 4/2/12 at 3:20 PM and when asked about client #8's temperature of 104 degrees, she stated, "A lot of time we'll ask for a second reading. I wasn't sure if the thermometer was accurate." She indicated it was standard practice to allow the medication to work before assessing the client, she was unaware of client #8's history of rapid onset of pneumonia, and stated, "I heard his congestion when I arrived and knew he had to be seen. If I had known he had</p>				

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	congestion, I would have sent him right away." 9-3-6(a)				

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W0346	<p>483.460(d)(4) NURSING STAFF</p> <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview, for 8 of 8 clients who lived in the home (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to have a Registered Nurse (RN) on staff or to have a formal arrangement with an RN to be available for verbal or onsite consultations to the LPNs (licensed practical nurses).</p> <p>Findings include:</p> <p>BDDS reports regarding client #8 were reviewed on 3/29/12 at 10:45 AM. A report dated 1/1/12 indicated client #8 had been transported to the hospital, evaluated for a fever of 104 degrees and general breathing trouble per the agency nurse and asthma risk plan. He was diagnosed with pneumonia and admitted to ICU (intensive care unit). A report dated 1/4/12 indicated client #8 had passed away while in the hospital at 5:45 PM.</p> <p>The facility's review of client #8's death was reviewed on 3/29/12 at 11:36 AM. A Health Care Support Plan dated 12/2/11 indicated client #8 was "At High Risk for</p>	W0346	<p>The facility has an agreement with a medical office and a physician and his staff. On a monthly basis the facility nurse meets with the physician to review each individuals and medications. The physicians office is available for consult as needed. This agreement has been in place beyond 12 years. The facility does not agree that there is no consultation available to the nursing staff. Based on the review of the MRC, the facility nurse responded appropriately. If this appeal is not accepted, the DRO has begun contacting individuals, who in addition to our physician, will be available for consultation as needed. Currently the facility is awaiting response from an individual who expressed interest. The facility will continue to pursue this need as required. PERSON RESPONSIBLE: DRO</p>	04/18/2012	

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	<p>pneumonia d/t (due to weakened lungs)." The plan indicated client #8's PCP (primary care physician) was to be notified if client #8 developed a cough or fever. Staff were to monitor for s/s (signs and symptoms) of pneumonia and if any are noted to notify the PCP. Signs and symptoms to be monitored included fever and cough. A death certificate dated 1/6/12 indicated client #8's cause of death was "bacterial pneumonia." The history and physical exam from the hospital on 1/1/12 indicated client #8 had "two or three admissions to [hospital name] over the last two years for severe pneumonia." Client #8's temperature in the emergency room was 100.5 and the chest x-ray showed right side pneumonia.</p> <p>"Impression: 1. Bacterial pneumonia with sepsis syndrome. 2. Down's syndrome, profound mental handicap. 3. Prior history of aspiration pneumonia..."</p> <p>Consultation dated 1/1/12 indicated, "He has a longstanding history of dysphagia... He has been admitted at least four times at [hospital name] and at least 1 time to [another hospital name]. The patient's presentation is very typical of his previous hospitalizations...The patient was admitted and found to be in shock and is now in the intensive care unit...Assessment and Plan: Recurrent pneumonia related to aspiration related to Down's Syndrome. His respiratory illness</p>			

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	and critical illness at this point is clearly a manifestation of his impaired neurological status....His overall prognosis is exceedingly poor...." The ER (emergency room) Physician's report dated 1/1/12 indicated Diagnostic Impression: Septic shock and pneumonia...Disposition: Inpatient, critical...." The records indicated client #8 continued to deteriorate in the hospital, was removed from life support and died on 1/4/12. Quarterly progress/Nurses Notes dated 1/1/12 and signed by LPN #2 indicated at 1:11 AM she had received a phone call from "beeper that stated [group home] had called and was concerned about [client #8] that he had a temp (temperature) of 104. I told beeper to have them give him Tylenol to see if that helps and if it doesn't to let me know. I then received another call at 3:13 AM from beeper that staff was concerned about his breathing. I went to the house and assessed him. He was resting in bed and I could hear his congestion without using a stethoscope and I checked his biox (oxygen level reading) and it read in the lower 70's. I determined that he needed to go to ER to be evaluated. I assisted [staff] and we got him dressed and transferred him to her car and she left to go to the ER." Client #8's ISP dated 5/12/11 indicated "His lung health is still an on-going issue that is evaluated and			

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	<p>monitored by his PCP, [Doctor name]. Staff will continue to monitor his health closely to ensure he is not getting ill due to the recent past of becoming seriously ill very quickly. Staff will report any abnormal behavior, fatigue or trouble breathing to nurse and follow up with his PCP...." There was no evidence in the record that an RN was consulted regarding client #8's medical history or onset of illness on 1/1/12.</p> <p>LPN #1 was interviewed on 3/29/12 at 12:15 PM. She indicated there was not an RN on contract for consultation at the facility and a medical director was on staff for consultation on an as needed basis.</p> <p>LPN #2 was interviewed on 4/2/12 at 3:20 PM and when asked about client #8's temperature of 104 degrees, she stated, "A lot of time we'll ask for a second reading. I wasn't sure if the thermometer was accurate." She indicated it was standard practice to allow the medication to work before assessing the client, she was unaware of client #8's history of rapid onset of pneumonia, and stated, "I heard his congestion when I arrived and knew he had to be seen. If I had known he had congestion, I would have sent him right away." She did not indicate she had consulted with an RN regarding client</p>						

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	<p>#8's illness.</p> <p>Client #1's record was reviewed on 4/4/12 at 11:15 AM. Client #1's record indicated he had diagnoses of PKU (phenylketonuria), cataracts, leukocoria, attention deficit disorder with hyperactivity, kerataconus, Impulse control disorder not otherwise specified.</p> <p>Client #2's record was reviewed on 14/3/12 at 2:30 PM. Client #2's record indicated he had diagnoses of sickle cell disease, hernia, convulsive disorder, anemia, impulse control disorder, schizophrenia, dysphagia, allergic rhinitis.</p> <p>Client #3's record was reviewed on 4/3/12 at 4:00 PM. Client #3's record indicated he had diagnoses of Attention Deficit Disorder, Bi-polar disorder, seizure disorder, hypertension.</p> <p>Client #4's record was reviewed on 4/3/12 at 3:30 P. Client #4's record indicated he had diagnoses of dysphagia, seizures, hydrocephalus.</p> <p>9-3-6(a)</p>						

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 7 of 7 clients who received medications (clients #1, #2, #3, #4 #5, #6, #7), to administer medications per physician's orders.</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 3/28/12 at 4:20 PM and included the following:</p> <p>For client #1:</p> <ul style="list-style-type: none"> - A report dated 6/22/11 indicated client #1 did not received his complete dose of Depakote (mood instability) on the evening of 6/22/11. -A report dated 6/7/11 indicated client #1 did not receive his complete dosage of Depakote 125 mg (milligrams) capsules. -A report dated 9/22/11 indicated client #1 did not get his complete dosage of Divalproex 125 mg. He should have received 4 pills, but only received two. <p>For client #2:</p>	W0368	<p>On 4/6/12 all facility staff were trained by the facility nurse on medication administration. They were again trained on 4/17/12 given the same information. Staff have been trained on the use of the template, and that all staff are to use it for specific individuals. In order to prevent this in the future, the manager and QDDP will conduct medication check off forms two times per week to ensure compliance.Failure to comply will result in disciplinary action.Person Responsible: QDDP</p>	04/18/2012			

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	<p>-A report dated 9/8/11 indicated client #2 did not receive his 3 PM dosage of Dilantin 100 mg capsule (seizures).</p> <p>For client #3:</p> <p>-A report dated 2/7/12 indicated client #3 did not receive his complete dosage of Carbamazepine (mood stability) at 9:00 PM.</p> <p>-A report dated 7/18/11 indicated client #3 did not receive the correct dosage of his bedtime medication on 7/17/11. He received one, not three pills of Carbamazepine 200 mg and received one, not three Risperidone. 25 mg pills. The medications Risperdone and Tegretol are psychoactive medications.</p> <p>For client #4:</p> <p>-A report dated 5/13/11 indicated client #4 did not receive his am dosage of Bactrim DS 800/160 mg. Client #4 was to receive Bactrim for 7 days (antibiotic).</p> <p>-A report dated 4/12/11 indicated on 4/13/11 at 5:00 PM, client #4 did not get his entire dose of Lamictal (seizures).</p> <p>-A report dated 11/20/11 indicated client #4 didn't receive Omeprazole for GERD (gastroesophageal reflux disease).</p>						

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	<p>-A report dated 2/3/12 indicated client #4 didn't receive his complete dosage of Lamotrigine (seizures) 150 mg. He should have received two pills and received only one.</p> <p>-A report dated 10/6/11 indicated client #4 did not receive his complete dose of Oxcarbazepine 300 mg. He should have received two pills, but only received one.</p> <p>-A report dated 10/9/11 indicated client #4 did not receive his complete dose of Oxcarbazepine 300 mg. He should have received two pills, but only received one.</p> <p>-A report dated 9/21/11 indicated client #4 did not receive his complete dose of Oxcarbazepine 300 mg (seizures). He should have received two pills, but only received one.</p> <p>-A report dated 7/30/11 indicated client #4 did not receive his complete dosage of Lamotrigine 150 mg pills. He should have received two pills, but only received one.</p> <p>-A report dated 5/20/11 indicated client #4 did not receive his 1 AM dose of the antibiotic Clindamycin HCL (hydrochloride)/50 50 mg.</p>			

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	<p>For client #5:</p> <p>-A report dated 1/10/12 indicated client #5 didn't receive a complete dose of Seroquel 400 mg (mood instability). He should have received two pills, but only received one.</p> <p>-A report dated 1/7/12 indicated on 1/6/12 at 5:00 PM client #5 didn't receive his complete dosage of Depakote 125 mg sprinkles (mood instability). He should have received 8 capsules, but only received 4.</p> <p>-A report dated 8/18/11 indicated on 8/17/11 client #5 did not receive his complete dosage of Depakote. He should have received 3 pills, but only received one.</p> <p>-A report dated 6/21/11 indicated client #5 did not receive his full dose of Depakote on 6/20/11. He should have received three 500 mg pills, but only received one.</p> <p>-A report dated 5/14/11 indicated client #5 did not receive his complete dosage of Depakote. He should have received 3 pills, but only received one.</p> <p>-A report dated 5/12/11 indicated client #5 did not receive his complete dose of</p>				

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	<p>Vimpat 100 mg on 5/12/11. He should have received two pills, but only received one.</p> <p>-A report dated 4/12/11 indicated client #5 only received half his dosage of Depakote.</p> <p>For client #6:</p> <p>-A report dated 2/4/12 indicated client #6 did not receive his complete dosage of Depakote 125 mg (mood stability). He should have received 5 pills, but only received one.</p> <p>-A report dated 2/3/12 indicated client #6 didn't receive his 8:00 PM dose of Ativan .5 mg (mood instability).</p> <p>-A report dated 12/27/11 indicated client #6 did not receive Depakote 125 mg sprinkles. He should have received 4 capsules, but did not receive any.</p> <p>For client #7:</p> <p>- A report dated 12/25/11 indicated client #7 did not receive his Metformin 500 mg at 7:00 AM on 12/25/11.</p> <p>-A report dated 10/10/11 indicated client #7 did not receive his complete dosage of Metformin (diabetes). He should have</p>						

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	<p>received two pills, but only received one.</p> <p>The reports indicated staff would receive appropriate training and discipline for the medication administration errors.</p> <p>During the medication administration pass on 3/29/12 beginning at 6:55 AM, clients #4 and #6 received their medications from staff #10. Staff #10 reviewed the pill label and the medication administration record to determine which medications to administer to clients #4 and #6. There were no other aids used to determine which medications to administer.</p> <p>The house manager was interviewed on 3/29/12 at 8:07 AM and indicated medication errors had been addressed by implementing a template system for staff to use during medication administration, and another staff was to "buddy check" the medications to be passed to reduce errors.</p> <p>Staff #10 was interviewed on 3/29/12 at 8:10 AM and indicated the use of the template was for new staff to ensure medications were administered without error.</p> <p>The QMRP and nurse were interviewed on 4/4/12 at 12:20 PM and indicated the</p>				

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	<p>template was to be used to prevent ongoing errors.</p> <p>9-3-6(a)</p>				

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W0382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and 3 additional clients (clients #5, #6, and #7), the facility failed to ensure medications were kept locked when staff left the medication area.</p> <p>Findings include:</p> <p>During the medication administration pass on 3/29/12 beginning at 6:55 AM, staff #10 placed client #6's medication tablets into a cup and left the pills on the counter while she left the room and left the door to the administration room unsecured and open while she retrieved client #6's Lorazepam in the refrigerator. Clients #1, #2, #3, #4, #5, #6 and #7 were in the adjacent living room.</p> <p>Staff #10 was interviewed on 3/29/12 at 7:08 AM and indicated medications were to be locked when not being administered.</p> <p>9-3-6(a)</p>	W0382	<p>On 4/17/12 all facility staff were trained on not leaving medications unattended. Staff were trained to retrieve the referigerated medications prior to dispensing the other medications. In order to prevent this from happening again, the manager and QDDP will be conducting med administration check offs 2x week and this will be an area of focus. Failure to comply will result in disciplinary action. Person responsible: QDDP, LPN, Res Manager</p>	04/18/2012			