

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2016
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00185316.</p> <p>Complaint #IN00185316: Substantiated, Federal and state deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, W157, W318, W331 and W368.</p> <p>Unrelated deficiencies cited.</p> <p>Survey Dates: 1/13, 1/19, 1/20, 1/21 and 2/15/16.</p> <p>Facility Number: 006630 Provider Number: 15G744 AIM Number: 200902110</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/19/16.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and</p>	W 0102	<u>W102</u>	03/16/2016

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>record review, the governing body failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (B, C, D) and for 1 additional client (H). The governing body failed to ensure clients were not neglected in regard to a significant medication error and/or seizures. The facility's governing body failed to ensure the facility developed a system to monitor the work of its nursing staff and/or facility staff in regard to medication administration/and physician orders. The facility's governing body failed to ensure facility staff immediately reported allegations of abuse/neglect, conducted thorough investigations, and to ensure the facility put in place and/or implemented its recommended corrective actions from allegations of neglect, abuse and/or clients' falls. The facility's governing body failed to ensure the facility put in place a plan to allow a client to get back his right of movement. The facility's governing body failed to ensure the facility's nursing services met the health care needs of clients for whom it served.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 3 of 4 sampled clients (B, C and D) and for 1</p>		<p><b>Finding(s):</b> 1. <b>“Based on observation, record review, and interview, the governing body failed to meet the Condition of Participation; Client Protections for 3 of 4 sampled clients (B, C, and D) and for 1 additional client (H). The governing body failed to ensure that client D was not neglected in regard to the client's seizures and failed to ensure an allegation of abuse was immediately reported to the administrator.”</b></p> <p><b>Corrective Action(s):</b> To ensure that the governing body meets the Condition of Participation for Client Protections and ensure that client D is free of neglect in regard to client D's seizures and that all allegations of abuse is immediately reported to the administrator.</p> <p>1. The Assistant Residential Director will be completing a Periodic Service Review quarterly in the home to give additional administration oversight.</p> <p>2. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regards to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for</p>				

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	<p>additional client (H). The governing body failed to ensure client D was not neglected in regard to the client's seizures and failed to ensure an allegation of abuse was immediately reported to the administrator. The governing body failed to conduct thorough investigations in regard to allegations of abuse and/or neglect for clients B, C and D, failed to ensure the facility put in place corrective actions/measures, and/or implemented its recommended corrective actions/measures in regard to retraining staff for clients C and D. The governing body failed to ensure a client had a plan in place to get their restricted rights back in regard to the use of door and bed alarms for client C. Please see W122.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for 3 of 4 sampled clients (B, C and D). The governing body failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility. Please see W318.</p> <p>3. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of a client in regard to a significant medication error, and in regard to client D's seizures to ensure the health and</p>		<p>additional administrative oversight. 3.All staff located in the home will beretrained on reportable incidents, the procedure for reporting, and the abuse,neglect, and exploitation policy. Record of Training forms will be completedfollowing staff trainings and will be submitted to the Residential Director foradministrative oversight.</p> <p>- <b>Finding(s):</b> 1. "<i>The facility's governing body failed to conduct thorough investigation in regard toallegation of abuse and/or neglect for clients B, C, and D, failed to ensurethe facility put in place corrective actions/measures, and/or implemented itsrecommended corrective actions/measures in regard to retraining staff forclients C and D.</i> <b>CorrectiveAction(s):</b> Toensure that established agency policies and procedures for investigations arebeing implemented, corrective measures/actions are being implemented andexecuted as written in regard to retraining staff for all clients. 1.Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. All</p>		

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	<p>safety of the client. The governing body failed to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse, neglect and/or client to client aggression/abuse for clients B, C, D and H, and to ensure the facility implemented its recommended corrective actions and/or retrained staff in regard to a client's falls for clients C and D.</p> <p>The governing body failed to ensure the facility did not violate client C's rights in regard to the use of bed alarms with no titration plan in place. The governing body failed to ensure facility staff reported an allegation of staff to client abuse immediately to the administrator when the incident occurred for client D. The governing body failed to ensure the facility failed conducted a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, D and H.</p> <p>The governing body failed to ensure the facility put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to prevent significant medication errors for client D. The governing body failed to ensure the facility took appropriate corrective action in regard to retraining staff in regard to</p>		<p>investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of Training form will be completed for all trainings on corrective actions/measures for the corrective and be submitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Assistant Residential Director, and the Social Service Coordinator will be trained on the newly established investigation process. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>-</p>				

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	<p>client C's falls, and in regard to an allegation of staff to client abuse involving clients B and H.</p> <p>The governing body failed to ensure the facility's health care services met the nursing needs of clients. The governing body failed to ensure the facility's health care services assessed clients after a hospitalization, and transcribed medications correctly on a Medication Administration Record to prevent a significant medication error in regard to a client's seizure medication. The governing body failed to ensure the facility's health care services developed risk plans, updated risk plans, informed doctors of all medication errors, and to ensure clients' seizure medication levels were being periodically monitored to ensure the clients' optimum health.</p> <p>The governing body failed to ensure the facility's health care services ensured client D's seizure medications were administered as ordered by the client's doctor. Please see W104.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-1(a)</p>		<p><b>Finding(s):</b></p> <p><b>1. "The facility's governing body failed to ensure a client had a plan in place to get their restricted rights back in regard to the use of door and bed alarms for client C."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure that established plans are written and in place for the clients to get their right of freedom of movement back, the following correction actions will be implemented:</b></p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) will write and implement titration plans for client C to get their right of freedom of movement back in regard to the use of door and bed alarms. The QIDP will obtain approval for these plans from the Human Rights Committee (HRC) prior to implementation. All staff located in the home will be trained on any revisions and titration plans made to client C. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>-</p> <p><b>Finding(s):</b></p> <p><b>1. "The governing body failed to ensure the facility met the Condition of Participation. Health Care Services for 3 of 4 sampled clients (B, C, and D). The governing body failed to</b></p>				

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			<p><b>ensure its nursing services met the healthcare and nursing needs of each client who resides in the facility.”</b></p> <p><b>CorrectiveAction(s):</b></p> <p><b>Thegoverning body to ensure the facility meets the Condition of Participation forHealth Care Services. The governing body to ensure its nursing services meetthe healthcare and nursing needs of every client who resides in the facility.</b></p> <p>1.The Residential Nurse for this homehas been terminated and replaced with a Registered Nurse. The newly hiredRegistered Nurse will complete an extensive training period to ensure that thenurse can be thoroughly trained on all person served plans and agency policyand procedures. The skills and abilities of the nurse will be monitored by theResidential Director to ensure competency of the nurse in her position and thatthe needs of each person served is met.</p> <p>2.The Residential Registered Nurse willcomplete a Record of Training form for all orientation training. The Record ofTraining will be submitted to the Residential Director for administrativeoversight.</p> <p><b>Finding(s):</b></p> <p><b>1. “Thefacility's governing body failed to ensure the facility implemented its</b></p>		

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			<p><b>written policy and procedures to prevent neglect of a client in regard to a significant medication error, and in regard client D's seizures to ensure health and safety of the client.</b></p> <p><b>Corrective Action(s):</b></p> <p><b>The governing body to ensure implementation of established written policy and procedures are being implemented to prevent neglect of clients in regard to the health and safety of clients.</b></p> <p>1. The Assistant Residential Director will be completing a Periodic Service Review quarterly in the home to give additional administration oversight.</p> <p>2. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regards to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>3. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client.</p> <p>4. All staff located in the home will be trained on any/all changes made in regards to client D's medications and seizures. Record</p>	

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			<p>of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative</p> <p><b>Finding(s):</b>  <b>1. "The governing body failed to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse, neglect and/or client to client aggression/abuse and/or injuries of unknown origin for clients B, C, D, and H, and to ensure the facility implemented corrective actions and/or retrain staff in regard to a client's falls for clients C and D."</b></p> <p><b>Corrective Action(s):</b>                      The governing body to ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients. The governing body to ensure implementation of established written policy and procedures are being implemented to prevent neglect of clients in regard to the health and</p>	

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			<p><b>safety of clients.</b></p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of Training form will be completed for all trainings on corrective actions/measures for the corrective and be submitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>	

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			<p><b>Finding(s):</b></p> <p><b>1. "The governing body failed to ensure the facility staff reported an allegation of staff to client abuse immediately to the administrator when the incident occurred for client D."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure that all facility staff report all allegations of staff to client abuse, neglect, exploitation, or mistreatment immediately to the administrator.</b></p> <p>1. All staff located in the home will be immediately retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. To further ensure competency and understanding all staff located in the home will be retrained quarterly on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>-</p> <p>-</p>	

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			<p><b>Finding(s):</b></p> <p><b>1. "The governing body failed to ensure the facility put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to prevent significant medication errors for client D. The governing body failed to ensure the facility took appropriate corrective action in regard to retraining staff in regard to client C's falls, and in regard to an allegation of staff to client abuse involving clients B and H."</b></p> <p><b>Corrective Action(s):</b></p> <p>To ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients; to ensure implementation of established written policy and procedures are being implemented to prevent neglect of clients in regard to the health and safety of clients; and to ensure that staff/nurses are monitored, the following corrective action for governing bodies will be implemented.</p>	

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			<p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of Training form will be completed for all trainings on corrective actions/measures for the corrective and be submitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Assistant Residential Director, and the Social Service Coordinator will be trained on the newly established investigation process. Record of</p>	

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			<p>Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>3. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>4. The Assistant Residential Director will be completing a Periodic Service Review quarterly in the home to give additional administration oversight over nursing and health care services.</p> <p>5. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regards to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>- <b>Finding(s):</b> 1. <i><b>The governing body failed to ensure the facility's health care services assessed clients after a hospitalization, and transcribed medications correctly on a Medication Administration Record to prevent a significant medication error in regard to</b></i></p>	

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			<p><b>client's seizure medication."</b></p> <p><b>CorrectiveAction(s):</b>  <b>Governingbody to ensure the facility's health care services assess clients after ahospitalization, and transcribe medications correctly on a MedicationAdministration Record for prevention of errors.</b></p> <p>1.TheResidential Nurse will be trained on all protocols for medical services for personserved following a hospitalization. To ensure that all persons served medicalneeds are met and that all agency protocols are followed following ahospitalization, the Residential Nurse will complete a Post Hospitalizationchecklist and submit to the Residential Director for review and administrativeoversight.</p> <p><b>Finding(s):</b>  <b>1."Thegoverning body failed to ensure the facility's health care services developedrisk plans, updated risk plans, informed doctors of all medication errors, andto ensure clients' seizure medication levels were being periodically monitoredto ensure the clients' optimum health."</b></p> <p><b>CorrectiveAction(s):</b>  <b>Governingbody to ensure the</b></p>		

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			<p><b>facility's health care services develop risk plans, updatet risk plans, inform doctors of all medication errors, and to ensure clients' medication levels are being periodically monitored to ensure clients optimum health.</b></p> <p>1. Aspart of the Periodic Service Review process, the Assistant Director will review nursing notes, client notes and all plans to ensure accuracy and all information is current and updated.</p> <p><b>1. "The governing body failed to ensure the facility's health care services ensured client D's seizure medications were administered as ordered by the client's doctor."</b></p> <p><b>Corrective Action(s):</b> <b>Governing body to ensure the facility's health care services administer clients' medications according to doctor orders.</b></p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regardsto his seizure activity, health, and any appointments that were attended forthat week and any upcoming appointments for additional administrative oversight.</p> <p>2. The Residential Nurse will give the Residential Director a report every time thereis a doctor</p>		

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W 0104  Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 4 sampled clients (B, C and D), the governing body failed to exercise general policy and operating direction over the facility to ensure clients were not neglected in regard to a significant medication error and/or seizures. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a system to monitor the work of its nursing staff and/or facility staff in regard to medication administration/and physician orders. The facility's governing body failed to exercise general policy and operating direction over the facility to	W 0104	ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client. 3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders.  <b>W104</b> <b>Finding(s):</b> 1. "The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of a client in regard to client D's seizures to ensure health and safety of the client." <b>Corrective Action(s):</b> The governing body to ensure implementation of established written policy and procedures are being implemented to prevent neglect of clients in regard to the health and safety of clients. 1. The Assistant Residential	03/16/2016	

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	<p>ensure facility staff immediately reported allegations of abuse/neglect, conducted thorough investigations, and to ensure the facility put in place and/or implemented its recommended corrective actions from allegations of neglect, abuse and/or clients' falls. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility put in place a plan to allow a client to get back his right of movement. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of clients for whom it served.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of a client in regard to a significant medication error, and in regard to client D's seizures to ensure the health and safety of the client. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard</p>		<p>Director will be completing a Periodic Service Review quarterly in the home to give additional administration oversight.</p> <p>2. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regards to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>3. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client.</p> <p>4. All staff located in the home will be trained on any/all changes made in regards to client D's medications and seizures. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative</p> <p><b>Finding(s):</b></p> <p><b>1. "The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct thorough investigations in</b></p>	

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	<p>to allegations of staff to client abuse, neglect and/or client to client aggression/abuse for clients B, C, D and H, and to ensure the facility implemented its recommended corrective actions and/or retrained staff in regard to a client's falls for clients C and D. Please see W149.</p> <p>2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not violate client C's rights in regard to the use of bed alarms with no titration plan in place. Please see W125.</p> <p>3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported an allegation of staff to client abuse immediately to the administrator when the incident occurred for client D. Please see W153.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, D and H. Please see W154.</p> <p>5. The facility's governing body failed to</p>		<p><b>regard to allegations of staff to client abuse, neglect and/or client aggression to clients B, C,D, and H, and to ensure the facility implemented its recommended correctiveactions and/or retrained staff in regard to client's falls for clients C and D."</b></p> <p><b>CorrectiveAction(s):</b> <b>Toensure that established agency policies and procedures for investigations arebeing implemented, corrective measures/actions are being implemented andexecuted as written in regard to retraining staff for all clients; and toensure established written policy and procedures are being implemented toprevent neglect of clients in regard to the health and safety of clients, thefollowing corrective actions will be implemented.</b></p> <p>1. Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. All investigations include appropriatecorrective action and that all corrective actions/measures are implemented inregards to retraining staff for clients. To ensure that all correctiveactions/measures are</p>	

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	<p>exercise general policy and operating direction over the facility to ensure the facility put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to prevent significant medication errors for client D. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility took appropriate corrective action in regard to retraining staff in regard to client C's falls, and in regard to an allegation of staff to client abuse involving clients B and H. Please see W157.</p> <p>6. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services met the nursing needs of clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services assessed clients after a hospitalization, and transcribed medications correctly on a Medication Administration Record to prevent a significant medication error in regard to a client's seizure medication. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services developed risk plans, updated</p>		<p>implemented, a Record of Training form will be completed for all trainings on corrective actions/measures for the corrective and be submitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Assistant Residential Director, and the Social Service Coordinator will be trained on the newly established investigation process. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>3. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative</p>	

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	<p>risk plans, informed doctors of all medication errors, and to ensure clients' seizure medication levels were being periodically monitored to ensure the clients' optimum health. Please see W331.</p> <p>7. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services ensured client D's seizure medications were administered as ordered by the client's doctor. Please see W368.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-1(a)</p>		<p>oversight.</p> <p><b>Finding(s):</b> 1. <i>"The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not violate client C's rights in regards to the use of bed alarms with no titration plan in place."</i></p> <p><b>CorrectiveAction(s):</b> To ensure that established plans are written and in place for the clients to get their right of freedom of movement back, the following correction actions will be implemented: 1. The Qualified Intellectual Disabilities Professional (QIDP) will write and implement titration plans for client C to get their right of freedom of movement back in regard to the use of door and bed alarms. The QIDP will obtain approval for these plans from the Human Rights Committee (HRC) prior to implementation. All staff located in the home will be trained on any revisions and titration plans made to client C. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>		

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			<p>-</p> <p>-</p> <p><b>Finding(s):</b></p> <p><b>1. "The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility staff reported an allegation of staff to client abuse immediately to the administrator when the incident occurred for client D."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>The governing body will exercise general policy and operating direction over the facility and to ensure that the facility staff report all allegations of staff to client abuse immediately to the administrator, the following corrective actions will be implemented.</b></p> <p>1. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. To further ensure competency and understanding all staff located in the home will be retrained quarterly on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed</p>	

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			<p>following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>- <b>Finding(s):</b> 1. <b><i>"The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, D, and H."</i></b></p> <p><b>Corrective Action(s):</b> The governing bodies will ensure that established agency policies and procedures for conducting thorough investigations are being implemented for all allegations of abuse, neglect and/or injuries of unknown source, by implementing the following corrective actions.</p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of Training form will be completed for</p>	

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			<p>all trainings on corrective actions/measures for the corrective and besubmitted to the Social Service Coordinator for review. The Social ServiceCoordinator will take a copy of the Record of training completed for thetraining and attached it to the investigation to ensure completion. Theinvestigations will be reviewed weekly by the Residential Director to ensuretrainings have been completed in accordance to the implemented correctiveactions/measures.</p> <p>2.All investigations that are completed by the Social Service Coordinator will bereviewed by the Assistant Residential Director, The Residential Director, andThe executive Vice President for additional administrative oversight to ensureinvestigations are completed thoroughly and in accordance to written policy andprocedures.</p> <p>- <b>Finding(s):</b> 1. <b><i>"The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility put corrective actions/measures in place to ensure staff weretrained, and to monitor staff/nurses to prevent significant medication errors for client D. The facility's governing body failed to exercise general policy and operating direction over the</i></b></p>	

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			<p><b>facility to ensure the facility took appropriate corrective action in regard to retraining staff in regard to client C's falls, and in regard to an allegation of staff to client abuse involving clients B and H."</b></p> <p><b>Corrective Action(s):</b> To ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients; to ensure implementation of established written policy and procedures are being implemented to prevent neglect of clients in regard to the health and safety of clients; and to ensure that staff/nurses are monitored, the following corrective actions will be implemented.</p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all</p>	

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			<p>correctiveactions/measures are implemented, a Record of Training form will be completedfor all trainings on corrective actions/measures for the corrective and besubmitted to the Social Service Coordinator for review. The Social ServiceCoordinator will take a copy of the Record of training completed for thetraining and attached it to the investigation to ensure completion. Theinvestigations will be reviewed weekly by the Residential Director to ensuretrainings have been completed in accordance to the implemented correctiveactions/measures.</p> <p>2. Toensure that all investigations are conducted in a uniform and consistentmanner, all Residential House Managers, Qualified Individual Disabilities Professionals,Nurses, Assistant Residential Director, and the Social Service Coordinator willbe trained on the newly established investigation process. Record of Trainingforms will be completed following staff trainings and will be submitted to theResidential Director for administrative oversight.</p> <p>3. Allstaff located in the home will be retrained on reportable incidents, theprocedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and willbe submitted to the Residential</p>	

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			<p>Director for administrative oversight.</p> <p>4. The Assistant Residential Director will be completing a Periodic Service Review quarterly in the home to give additional administration oversight over nursing and health care services.</p> <p>5. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regards to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight</p> <p><b>Finding(s):</b></p> <p><b>1. "The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services met the nursing needs of clients. The facility's governing body failed to exercise general policy and operating direction over the facility's health care services assessed client's after hospitalization, transcribed medications correctly on a Medication Administration Record to prevent a significant medication error in regard to client's seizure medication."</b></p> <p><b>-</b></p> <p><b>Corrective Action(s):</b> Governing body to ensure the facility's health care services assess clients after a hospitalization, and transcribe</p>		

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			<p><b>medications correctly on a Medication Administration Record for prevention of errors.</b></p> <p>1. The Residential Nurse will be trained on all protocols for persons served following a hospitalization. To ensure that all persons served medical needs are met and that all agency protocols are followed following a hospitalization, the Residential Nurse will complete a Post Hospitalization checklist and submit to the Residential Director for review and administrative oversight.</p> <p>- <b>Finding(s):</b> 1. "The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services developed risk plans, updated risk plans, informed doctors of all medication errors, and to ensure clients' seizure medication levels were being periodically monitored to ensure clients' optimum health."</p> <p><b>Corrective Action(s):</b> To exercise general policy and operating direction over the</p>	

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			<p><b>facility to ensure the facility's health care services develops risk plans, updated risk plans, inform doctors of all medication errors, and to ensure clients' medication levels are being periodically monitored to ensure clients' optimum health, the governing body will implement the following corrective actions.</b></p> <p>1. As part of the Periodic Service Review process, the Assistant Residential Director will review all nursing notes and person served plans to ensure they are accurate and current information.</p> <p>- <b>Finding(s):</b> 1. "The facility's governing body failed to exercise general policy and operating direction over the facility's health care services ensured client D's seizure medications were administered as ordered by the client's doctor."</p> <p><b>Corrective Action(s):</b> Governing body to ensure the facility's health care services administer clients' medications according to doctor orders.</p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regard to his seizure activity, health, and any appointments that were attended for that week and</p>	

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W 0122  Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (B, C and D) and for 1 additional client (H). The facility failed to ensure a client was not neglected in regard to the client's seizures and failed to ensure an allegation of abuse was immediately reported to the administrator. The facility failed to conduct thorough investigations in regard to allegations of abuse and/or neglect, failed to ensure the facility put in place corrective actions/measures, and/or	W 0122	any upcoming appointments for additional administrative oversight. 2. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client. 3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders.  <b>W122</b> <b>Finding(s):</b> <b>1. "The facility failed to implement its written policy and procedures to prevent neglect of a client in regard to a significant medication error, and in regard to client D's seizures to ensure the health and safety of the client."</b> <b>Corrective Action(s):</b> <b>Governing body to ensure the facility's health care services administer clients' medications according to doctor orders to ensure health and safety of</b>	03/16/2016	

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	<p>implemented its recommended corrective actions/measures in regard to retraining staff. The facility failed to ensure a client had a plan in place to get their restricted rights back in regard to the use of door and bed alarms.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policy and procedures to prevent neglect of a client in regard to a significant medication error, and in regard to client D's seizures to ensure the health and safety of the client. The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse, neglect and/or client to client aggression/abuse for clients B, C, D and H, and to ensure the facility implemented its recommended corrective actions and/or retrained staff in regard to a client's falls for clients C and D. Please see W149.</p> <p>2. The facility failed to ensure client C's rights were not violated by the use of bed alarms with no titration plan in place. Please see W125.</p> <p>3. The facility failed to ensure its staff reported an allegation of staff to client</p>		<p><b>theclient.</b></p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regard to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>2. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client.</p> <p>3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders.</p> <p><b>Finding(s):</b></p> <p><b>1. "The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to allegation of staff to client abuse, neglect, and/or client to client aggression/abuse for clients B, C, D, and H, and to ensure the facility implemented its recommended corrective actions and/or</b></p>	

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	<p>abuse immediately to the administrator when the incident occurred for client D. Please see W153.</p> <p>4. The facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, D and H. Please see W154.</p> <p>5. The facility failed to put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses' to prevent significant medication errors for client D. The facility failed to take appropriate corrective action in regard to retraining staff in regard to client C's falls, and in regard to an allegation of staff to client abuse involving clients B and H. Please see W157.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-2(a)</p>		<p><b><i>retrained staff in regard to aclient's fall for clients C and D."</i></b></p> <p><b>CorrectiveAction(s):</b> <b>Thegoverning body to ensure that established agency policies and procedures forinvestigations are being implemented, corrective measures/actions are beingimplemented and executed as written in regard to retraining staff for allclients. The governing body to ensure that established agency policies andprocedures for conducting thorough investigations are being implemented for allallegations of abuse, neglect and/or injuries of unknown source.</b></p> <p>1.Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. All investigations include appropriatecorrective action and that all corrective actions/measures are implemented inregards to retraining staff for clients. To ensure that all correctiveactions/measures are implemented, a Record of Training form will be completedfor all trainings on corrective actions/measures for the corrective and besubmitted to the Social Service Coordinator for</p>		

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			<p>review. The Social ServiceCoordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Residential Director of Quality Assurance and Social Service Coordinator, and the Social Service Coordinator will be trained on the newly established investigation process. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>3. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p><b>Finding(s):</b> <b>1. "The facility failed to ensure client C's rights were</b></p>	

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			<p><b>not violated by the use of bed alarms with no titration plan in place."</b></p> <p><b>CorrectiveAction(s):</b> Toensure that established plans are written and in place for the clients to gettheir right of freedom of movement back, the following correction actions willbe implemented:</p> <p>1.TheQualified Intellectual Disabilities Professional (QIDP) will write andimplement titration plans for client C to get their right of freedom ofmovement back in regard to the use of door and bed alarms. The QIDP will obtainapproval for these plans from the Human Rights Committee (HRC) prior toimplementation. All staff located in the home will be trained on any revisionsand titration plans made to client C. Record of Training forms will becomepleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.</p> <p><b>Finding(s):</b> <b>1."The facility failed to ensure itsstaff reported an allegation of staff to client abuse immediately to theadministrator when the incident occurred for client D."</b></p> <p><b>CorrectiveAction(s):</b> Toensure the facility staff</p>		

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			<p><b>report all allegations of staff to client abuse immediately to the administrator</b></p> <p>1. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. To further ensure competency and understanding all staff located in the home will be retrained quarterly on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p><b>Finding(s):</b></p> <p><b>1. "The facility failed to conduct a thorough investigation in regard to the allegation of abuse, neglect, and/or injuries of unknown source for client's B, D, and H."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure the facility staff report all allegations of abuse, neglect, and/or injuries of unknown source immediately to the administrator</b></p> <p>1. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect,</p>		

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			<p>and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>2. All staff located in the home will be retrained quarterly on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>- <b>Finding(s):</b> 1. "The facility failed to put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to prevent significant medication errors for client D. The facility failed to take appropriate corrective action in regard to retraining staff in regard to client C's falls, and in regard to an allegation of staff to client abuse involving clients B and H."</p> <p>- <b>Corrective Action(s):</b> To implement corrective actions/measures to ensure staff are trained and to monitor staff/nurses to prevent medication errors for all clients. To implement corrective action in regard to retraining staff for falls and allegations</p>	

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W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview for 1 of 4 sampled clients (C) the facility failed to ensure client C's rights were not violated by the use of bed alarms with no titration plan in place.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 1/20/16 at 1:26pm. Client C's 6/5/15 HRC (Human Rights Committee) letter indicated the facility obtained approval for the use of bed alarms on client C's</p>	W 0125	<p><b>ofstaff to client abuse.</b> 1.All staff working in the home will be trained on any revisions, updates, or new client plans prior to implementation.To ensure that trainings have occurred the Residential Nurse or Residential Qualified Disabilities Professional (QIDP) will send a copy of the new or revised plans along with the Record of Training forms to the Residential Director for review and additional administrative oversight.</p> <p>-</p> <p><b>W125</b> <b>Finding(s):</b> <b>1. "Based on record review and interview for 1 of 4 sampled clients @ the facility failed to ensure client C's rights were not violated by the use of bed alarms with no titration plan in place."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure that established plans are written and in place for the clients to get their right of freedom of movement back, the following correction actions will be implemented:</b></p>	03/16/2016	

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W 0149 Bldg. 00	<p>bed. The HRC letter indicated client C "wakes up and crawls into other housemates' rooms... We are requesting the bed alarm for [client C's] bed so staff will immediately be aware when [client C] has gotten out of bed. "</p> <p>Client C's May 2015 BSP (Behavior Support Plan) did not indicate the use of a bed alarm or that client C had a behavior of crawling into other housemates' rooms. Client C's BSP did not indicate a titration plan for the use of the bed alarms.</p> <p>Interview with the Director of Residential Services (DRS) and Administrative staff #1 was conducted on 1/21/16 at 3:04pm. The DRS and Administrative staff #1 indicated the use of the bed alarms should have been addressed in the BSP.</p> <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 3 of 4 sampled clients (B, C and D) and for 1 additional client (H), the facility neglected to implement its written policy and procedures to prevent neglect of a</p>			W 0149	<p>1. The Qualified Intellectual Disabilities Professional (QIDP) will write and implement titration plans for client C to get their right of freedom of movement back in regard to the use of door and bed alarms. The QIDP will obtain approval for these plans from the Human Rights Committee (HRC) prior to implementation. All staff located in the home will be trained on any revisions and titration plans made to client C. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p><b>W149</b> <b>Finding(s):</b> <b>1. "Based on interview and record review for 3 of 4 sampled clients (B, C, and D) and for 1 additional client (H), the</b></p>		03/16/2016

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	<p>client in regard to a significant medication error, and in regard to the client's seizures to ensure the health and safety of the client. The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse, neglect and/or client to client aggression/abuse, and to ensure the facility implemented its recommended corrective actions and/or retrained staff in regard to a client's falls.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-1/4/16 "[Client D] was discharged from the hospital on 12/24/2015. His MAR (Medication Administration Record) had previously had doctors orders for Phenobarb (Phenobarbital-seizures) 64.8mg (milligrams) tab (tablet), take 2 tablets by mouth every night at bedtime on it. Upon discharge from the hospital on 12/24/2015 the doctor's discharge orders were 32.4mg tab take 129.6mg</p>		<p><b>facility neglected to implement its written policy and procedures to prevent neglect of a client in regard to a significant medication error, and in regard to the client's seizures to ensure the health and safety of the client."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure the facility's health care services/staff administer clients' medications according to doctor orders to ensure health and safety of the client.</b></p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regard to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>2. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client.</p> <p>3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders.</p>	

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	<p>oral at bedtime. The Residential Nurse altered the MAR at the group home, to match the current doctor orders, she transcribed the order incorrectly on 12/24/2015 and wrote Phenobarb 129.6mg (64.8 mg) take 4 tablets by mouth every night at bedtime. [Client D] received a double dose of his Phenobarbital from 12/24/2015 to 1/2/2016. The Residential House Manager found the error on 1/4/2016, [client D] was taken to the ER (emergency room), labs were drawn, his doctor was notified, he was discharged and sent back to the group home. [Client D] had a follow up appointment with his GP (General Practice) doctor today. His Phenobarbital level from the labs taken yesterday were within normal limits. Doctor is holding the Phenobarbital until Thursday as a precaution and ordered a repeat lab draw on Monday, 1/11/2016. The Residential Nurse making the error was immediately suspended and an investigation was started. Plan to Resolve [Client D] will continue to be monitored for any adverse affect of receiving too much Phenobarbital...."</p> <p>The facility's 1/12/16 Residential Services Investigation Checklist indicated the facility conducted an investigation in regard to client D's</p>		<p>4.Allstaff located in the home will be trained on all medication changes ordered by a physician when they occur. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>Finding(s): <b>1. "The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse, neglect and/or client to client aggression/abuse, and to ensure the facility implemented its recommended corrective actions and/or retrained staff in regard to client's falls."</b></p> <p>-</p> <p>-</p> <p>Corrective Action(s): To ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients; To ensure that established agency policies and procedures for conducting thorough investigations are being implemented for all allegations of abuse, neglect</p>				

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	<p>significant medication error. The facility's 1/12/16 investigation indicated the nurse who made the error was an RN (Registered Nurse). The facility's investigation indicated facility staff, who worked in the group home, were told to administer 4 tablets of client D's Phenobarbital by the nurse and/or other staff as instructed. The facility's investigation indicated "...12/11/15 The Phenobarb was stopped by the doctor due to [client D] being lethargic. He was taken to the hospital on 12-13-15, and was found to be septic. On 1/1/16 Carvedilol was stopped per doctors (sic) orders because [client D's] blood pressure was so low. On 1/1/16 it was noted that [client D] had received 4 64.8mg tabs of Phenobarb on both 1/1 and 1/2...On January 4th, it was brought to the attention of the Director of Residential Services that person served [client D] had been receiving a double dose of his medication Phenobarbital for ten days. [RN #1], the nurse that transcribed the wrong dosage, was immediately suspended pending an investigation...When [client D] was released from the hospital the doctor had prescribed him to take 4 tabs at 32.4mg per pill at bed time every night. However, [client D] was already on the medication, so the pharmacy just continued with the same pills. The pills</p>		<p><b>and/or injuries of unknown source, the following corrective actions will be implemented.</b></p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of Training form will be completed for all trainings on corrective actions/measures for the corrective and be submitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Residential Director of Quality Assurance and Social Service</p>				

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	<p>he was already on of the medication had 64.8mg per pill. The house manager stated that his Phenobarbitol (sic) had always been 64.8mg per tab. During the investigation, the house manager stated that [RN #1] had changed the Narcotic count record to say that staff were to administer 4 tabs of the Phenobarbitol (sic) instead of the 2 tabs that were prescribed. The house manager stated that she believed [RN #1] instructed the staff to administer 4 of the pills because she was going with what the hospital wrote the prescription for. The house manager stated that [RN #1] checked in the medications when they received them from the pharmacy, but she did not catch the error then. The house manager stated that she found the error when she went to the home and looked through all of the paperwork after another staff member had called her and told her that she felt like [client D's] medications needed to be looked at. The Team Lead from the house stated that she was passing meds on January 2nd (second), when she thought there was an issue. She stated that she gave [client D] two of the pills at first, but then ended up giving him a total of 4 of the pills because on the MAR it stated to administer 4 pill (sic). She stated that all of the staff before her had also given him 4 pills at every 8pm med (medication) time per the MAR. She</p>		<p>Coordinator, and the Social Service Coordinator will be trained on thenewly established investigation process. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.</p> <p>3.Allstaff located in the home will be retrained on reportable incidents, theprocedure for reporting, and the abuse, neglect, and exploitation policy.Record of Training forms will be completed following staff trainings and willbe submitted to the Residential Director for administrative oversight.</p>				

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	<p>stated that she still felt that it wasn't right, so she contacted the nurse. She stated that the nurse then told her to go with what the pharmacy sent as the dose...[RN #1], the nurse, stated that she instructed the staff to administer 4 pills per dose because the instructions from the hospital stated to administer 4 pills at 32.4mg were to be administered to amount to 129.6. She stated that the pharmacy gave them the other amount of medication in the pills. She stated that she first realized the error on Sunday when she went over to the home to assess [client D] due to him having low blood pressure. She stated that she got the pills out and then got her phone out and compared the pills to one another. She stated that she got the stickers out from the prescription and thought that the staff was administering the medication wrong. She stated that she then called the doctor to inform him of the situation. She stated the doctor informed her to hold the 8pm dose for the day, and then to take [client D] to get his labs done on Monday. She stated that she was the one that had transcribed the instructions for the staff to follow starting on December 24th to January 2nd. She stated that she had noticed signs that it may have been affecting him because he was lethargic and not himself on Sunday....Due to the medication error being significant, and lasting for ten days</p>			
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	<p>it is being recommended that the nurse from the group home be terminated...Also, all of the staff from the group home will be retrained on medication administration."</p> <p>Staff #1's 1/4/16 Investigation Interview Form also indicated client D was not given the correct dose of his Metronidazol (antibiotic) which was to be 500 mg two times a day but client D had only received Metronidazol 250 mg two times a day.</p> <p>RN #1's 1/5/16 Investigative Interview Form indicated she knew he was to receive the 32.4 mg tablets of Phenobarbital versus the 64.8 mg tablets. RN #1's statement indicated she was the one who had transcribed the order onto the MAR. RN #1's statement indicated "...The pharmacy gave us the other amount of medication..." RN #1's statement indicated she was the one who had realized the error on Sunday when she went to the group home to assess client D. RN #1's statement indicated she called the doctor once she realized staff had been giving the wrong medication.</p> <p>The facility's 1/12/16 investigation indicated the facility attached client D's hospital records from his 12/13/15 hospitalization. Client D's 12/24/15</p>			

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	<p>Patient Instructions for: Client D indicated "Discharge Diagnosis: Community acquired pneumonia (J18.9)." Client D's discharge summary indicated the client was discharged on a pureed diet with thickened liquids. The discharge summary indicated client D was treated for "...Left sided Pneumonia...Septic Shock...Seizure Disorder...." Client D's 12/24/15 discharge summary indicated client D was to receive the following medications (not all inclusive):</p> <p>"...Metronidazole 250 mg tab 500 mg PO (by mouth) twice a day twice a day Phenobarbital 32.4 mg tab 129.6 oral at bedtime...." The facility's nurse neglected to obtain clarification on the order if needed.</p> <p>An attached typed Medication Change note indicated "[Client D's] phenobarbital has been increased to 129.6 mg at 8 pm (sic) He is to receive 4 tablets at 8pm starting 12/24/2015. Please observe for over sedation (excessive drowsiness, difficulty with coordination, slurred speech) and report to the Residential Nurse on duty immediately." The medication change note neglected to specifically indicate the pill dosage of the 4 tablets the client was to receive as the note implied client D was to receive 4 tablets of 129.6 mg tablets.</p>			

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	<p>An attached client D's December 2015 MAR indicated under the medication sections: "Phenobarb 129.6 mg Take 4 tablets by mouth every night at bedtime (4 tabs)...*Give 4 tablets* each tablet 32.4 use 4 tabs to equal 129.6 mg" was written where staff sign their initials. The facility's investigation indicated the facility neglected to include documentation from the pharmacy on what Phenobarbital dosage was sent to the group home.</p> <p>Client D's December 2015 MAR indicated client D received Metronidazole 250 mg 1 tablet twice a day (half the dose of what was ordered) for 10 days. The facility's investigation neglected to address the medication error involving client D's antibiotic.</p> <p>An attached 12/24/15 Record Of Training Session, by RN #1, indicated "Title of Session: [Client D's] Medication Change Subject: phenobarbital 32.4 mg tablets-Increased Dose to 129.6 mg." The facility neglected to obtain clarification on the Phenobarbital order from the hospital, neglected to ensure client D's medications were transcribed onto the MAR correctly, neglected to ensure the facility monitored medications coming from the pharmacy to ensure correct dosing/medication was received,</p>			

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	<p>and neglected to ensure a system was put in place to catch potential medication errors before they were made.</p> <p>Client D's record was reviewed on 1/20/16 at 12:48 PM. Client D's Nurse's Notes indicated the following (not all inclusive):</p> <p>-1/1/16 "Staff called around 9 AM to report that [client D's] B/P (blood pressure) was low 88/65. Writer (LPN #1) called [name of doctor] to report. [Name of doctor] stated it could be due to the Carvedilol (hypertension-beta blocker) that was prescribed to him while he was in the hospital. [Name of doctor] asked that I go assess [client D]. Upon assessment B/P was 90/62, P (pulse): 60, R (respiration): 18, T (temperature): 94.0 temporal. [Client D] felt very cold to the touch. [Client D] was fairly lethargic. [Name of doctor] was called back and vitals were reported. [Name of doctor] stated he wanted the Carvedilol stopped and wanted [client D] monitored closely tonight and stated if his B/P dropped lower than 80/60 to take him to the ER (emergency room)...."</p> <p>-1/3/16 "Staff reported [client D] continues to be lethargic and vitals are 86/68, 84, 16 and 97.5 F (Fahrenheit). [Client D] can squeeze my hands equally</p>			

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	<p>in strength but he is weaker than his usual grips. He is appropriately answering yes/no questions. He is holding his head erect and appears somewhat sleepy. Upon review of records, it appears [client D] has received 4 64.8 mg tablets of phenobarbital on both January 1st (first) and January 2nd, @ (at) 8 pm. Called [name of doctor] to request directive. Awaiting return call." The entry was written by RN #1.</p> <p>-1/3/16 "[Name of doctor] returned call. Informed him of vitals and current level of function. Also informed him of [client D] receiving (4) 64.8 mg tablets instead of (2) 64.8 mg tablets on January 1st and January 2nd. [Name of doctor] stated to HOLD 8 pm phenobarbitol (sic) tonight. Also obtain phenobarbitol (sic) blood level Monday January 4, 2016. Once phenobarbitol (sic) blood level is obtained [name of doctor] will decide if staff are to hold Monday dose or administer the med. Staff have been directed to document ounces of fluid consumed every 2 hours and to obtain vitals every 2 hours. Will continue to observe."</p> <p>-1/4/16 Facility staff took client D to get the Phenobarbital lab. The note indicated staff was concerned about client D's "level of consciousness that he may need</p>			

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	<p>to be seen in the ER. [Client D] was taken to the ER around 230pm...." The note indicated the ER doctor checked client D and indicated it would take 24 hours for the client's Phenobarbital level to come back. The note indicated client D was sent home with instructions to monitor client D, and to hold the client's 8 PM Phenobarbital dose.</p> <p>-1/5/16 "[Name of doctor] gave a verbal order to hold phenobarbital until Thursday evening...Writer (LPN #1) put a hold on phenobarbital until Thursday (1/7/16)."</p> <p>-1/9/16 "Writer (LPN #1) was notified at 7:30am that [client D] had been taken to the ER for a series of cluster seizures that lasted for about 30 mins (minutes). Upon arrival at [name of hospital] ER...[name of doctor] came in and asked what had happened, [staff #2] explained what happened. Writer informed [name of doctor] that [name of doctor] had put a hold on the phenobarbital (sic) until Thursday (1-7-16) @ 8 pm when was to be resumed. [Staff #2] spoke up and stated it had not been resumed on Thursday (1-7-16). Upon looking at the MAR it appears that staff continued to hold med through Friday (1-8-16). Writer told [name of doctor] she was unclear as to why medication was not</p>			

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	<p>passed...." The note indicated client D was given an intravenous Phenobarbital and then sent back to the group home. The facility neglected to ensure client D received his medication as ordered.</p> <p>-1/9/16 (6:00 PM) The facility's nurse was called by staff as client D had "...been seizing for about 10 min. I (LPN #1) told [staff #2] I was on my way. [Staff #2] asked if it was ok to administer Diastat (rectal medication for seizures). Writer told her to follow protocol and Dr. (doctor) orders. [Staff #2] stated his Dr. orders stated to administer after 10 minutes of seizure activity. [Staff #2] administered rectal Diastat at 6:12 pm. When writer arrived [client D] was awake but not alert. [Client D] had several small tremors and [staff #2] swiped VNS (Vagal Nerve Stimulator) everytime, each time VNS was swiped [client D] stopped seizing...."</p> <p>-1/11/16 "late entry for 1/5/16 [Client D] was taken to [name of doctor] for a follow up from his hospital stay. [Name of doctor] gave us results of phenobarbital level -60- was the level... [Name of doctor] gave an order to hold pheno (phenobarbital) until Jan (January) 7th due to being toxic to his phenobarbital...." Client D's nursing notes indicated the facility neglected to</p>			

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	<p>document and/or inform client D's doctors of the medication errors prior to January 1 and January 2, 2016 (12/24/15 to 12/31/15). The facility's 1/12/16 investigation indicated the facility neglected to document/conduct a thorough investigation in regard to the 1/7/16 medication error with client D's Phenobarbital not restarting as ordered to prevent seizures.</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04 PM indicated client D had a seizure diagnosis. Administrative staff #1 and the DRS indicated there had been 2 medication errors in regard to the client's Phenobarbital. LPN #1 indicated she did not know why the staff did not restart client D's Phenobarbital on 1/7/16 as ordered. Administrative staff #1 and the DRS indicated the facility conducted an investigation in regard to client D's medication errors. LPN #1 stated "I told them what to do but staff did not follow." Administrative staff #1 and the DRS indicated RN #1 was terminated due to the 12/24/15 to 1/2/16 medication error with client D's double dosing of the Phenobarbital on 1/10/16. LPN #1, administrative staff #1 and the DRS stated client D had been in the hospital and was discharged on 12/24/15 for</p>			

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	<p>Pneumonia and "Phenobarbital toxicity." The DRS indicated RN #1 transcribed the order on the MAR wrong and facility staff #1 caught the error on 1/4/16. LPN #1, administrative staff #1 and the DRS indicated facility staff had been trained in regard to medication administration. LPN #1 indicated she had trained staff on administering client D's medication changes and orders. LPN #1 indicated she would look for the documented training, but did not provide any additional training documentation. Administrative staff #1 and the DRS stated "Oversight was missing after the first error." Administrative staff #1 indicated the facility did not put any additional measures/system in place to ensure the nurses transcribed orders correctly and/or staff administered medications as ordered. Administrative staff #1 indicated they had spoken with LPN #1 in regard to what the facility expected. Administrative staff #1 and the DRS stated "She (nurse) will have to be monitored and expectations made with staff." The facility did not provide any additional documentation in regard to the recommended retraining of staff in Core A and B medication administration and documentation.</p> <p>2. The facility's reportable incident reports and/or investigations were</p>			

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	<p>reviewed on 1/19/16 at 12:50 PM. Client D's 10/23/15 reportable incident report indicated on 10/22/15, "At approximately 12:30pm [client D] began having a cluster of seizures for the second time. Diastat was administered but was not effective and [client D] continued to have seizures. Staff (per [client D's] Seizure Risk Plan) called an ambulance and [client D] was transported to [name of hospital]. While in transport to the hospital [client D] was administered 20 mg of Valium (seizures) from the Paramedics but continued to have seizures...." The reportable incident report indicated labs and a chest Xray were performed in the ER. The reportable incident report indicated client D was released and the facility's nurse transported the client home. The 10/22/15 reportable incident report indicated "...With less than 2 blocks traveled [client D] began to have a grand mal seizure. Residential Nurse pulled to the side of the road to ensure [client D] was in a safe position to attempt to prevent injury from the seizure he was having. Residential Nurse called the ER and notified them that she was returning with [client D] having a grand mal seizure. ER nurse and the paramedics met [client D] at the door and transported him back into the ER. [Client D] was administered 10 mg of Valium through</p>			

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	<p>an IV (intravenous) from the ER doctor but continued to have seizures. The ER doctor then administered a 15 minute dose of Keppra (seizure) through the IV. This was successful in stopping the grand mal seizure. The ER doctor observed [client D] and found that his body was relaxed due to the medication but there was still some seizure activity as [client D's] cheeks were twitching. The ER doctor administered 10 mg of versed (seizure) which was successful in stopping all seizure activity. [Client D] was admitted to ICU (Intensive Care Unit) for observation. There was no more seizure activity. The lab work revealed that [client D] was low on potassium. ICU nurse administered potassium to [client D] and stated that one dosage should return his potassium to a normal level. [Client D] was released from the hospital to return home on 10/23/15 with no medication changes...Staff will continue to follow [client D's] Seizure Risk Plan as well as all risk plans...."</p> <p>The facility's 10/30/15 follow up report to the 10/23/15 reportable incident report indicated "...[Client D] was seen by his Neurologist, [name of doctor], for an evaluation. [Name of doctor] determined that [client D] had the seizures due to flu like symptoms. There are no changes at</p>			

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	<p>this point and time...." The facility's follow-up report indicated client D was to return to the doctor in 6 months unless he had seizures, and then the client was to return to see the neurologist at that time.</p> <p>Client D's record was reviewed on 1/20/16 at 12:48 PM. Client D's 10/27/15 physician's orders indicated client D's diagnosis included, but was not limited to, Seizure Disorder.</p> <p>Client D's hospital records, Discharge Instructions, Transition of Care Plans and Patient Plans indicated the following (not all inclusive):</p> <p>-2/20/15 Client D's Transition of Care Record indicated client D's Primary diagnosis was "1) Seizure Disorder 2) Acute hypokalemia (low potassium)." Client D's 2/20/15 Discharge Instructions indicated client D was seen in the ER due to seizures. Client D's discharge instructions indicated client D should eat foods like honey dew melons, potatoes, peaches, orange juice, tomato juice and meats to increase his potassium level.</p> <p>-10/22/15 Client D's Discharge Instructions indicated client D's diagnoses included, but were not limited to, "Seizure disorder (sic) Intractable" and "Status epilepticus (sic)."</p>			

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	<p>-12/24/15 Client D's Discharge Instructions indicated client D was admitted to the hospital on 12/13/15 for "Left sided Pneumonia," Septic Shock and Seizure Disorder. Client D's discharge instructions indicated the client was placed on a pureed diet with thickened liquids. Client D's 12/24/15 Patient Plan indicated client D had "Phenobarbitol Toxicity (dangerous high levels)" as well.</p> <p>-1/4/16 Transition of Care Record indicated client D was seen in the ER due to an "Altered Mental Status." The care plan indicated client D had a "...Primary Diagnosis 1) Decreased level of consciousness 2) Free text Dx (diagnosis): phenobarbitol (sic) overmedication Chief Complaint 1) Drug toxicity/reaction to phenobarbitol 2) Drug toxicity/complication...."</p> <p>-1/9/16 Client D was seen in the ER due to seizures.</p> <p>Client D's Physician Statements, Patient Plans and notes indicated the following (not all inclusive):</p> <p>-4/1/15 Client D saw his Neurologist for "increased seizure activity-med changes." The Neurologist did not make any</p>			

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	<p>changes at that time.</p> <p>-6/10/15 Client D saw the Neurologist for a VNS check. The 6/10/15 report did not indicate any changes in client D's medications. The 6/10/15 report/statement indicated "...stable last 2 1/2 mo (months)...."</p> <p>-10/8/15 Client D saw a nurse practitioner due to client D demonstrating "lethargy-difficulty walking." The note indicated labs and Phenobarbital and Valium (seizure) levels were ordered. The note indicated "observe for fall-due to being high fall risk."</p> <p>-10/28/15 Client D saw his Neurologist. The note indicated no changes were made in regard to client D's seizure medications.</p> <p>-12/11/15 Hand written note written by RN #1 indicated "[Client D] has been lethargic the past 3-4 days. Labs were drawn 12/9 and phenobarb level is &gt; (greater than) 80 meq/ml (milliequivalents/millimeters). Lamictal (seizure) level is pending. Please review and advise on how to proceed with [client D's] medication regimen." The bottom of the note indicated client D's Neurologist replied "Stop phenobarb check on Monday."</p>			

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	<p>-1/5/16 Client D saw his primary care doctor for follow up due to the client's hospitalization for pneumonia. The note indicated "Pt (patient) with Phenobarbital Toxicity seen in ER yesterday. Doing well with Pneumonia (after) Hospitalization...Watch for increased sedation. Speech eval (evaluation) for swallowing." An attached 1/4/16 lab page indicated client D's Phenobarbital was "64.4 H" (high-normal range 15.0 to 40.0). The 1/4/16 lab report indicated Phenobarbital was considered "toxic" when the level was greater than 50.0. The lab report indicated client D's last dose of the Phenobarbital was on "1-2-16 @ 2000 (8 PM)." The lab report indicated client D's Phenobarbital level was a "critical laboratory result" and it indicated "CALL RESULTS STAT (right away) TO [NAME OF DOCTOR]."</p> <p>-1/5/16 Client D's Patient Plan indicated the client was seen by his primary physician for "Phenobarbital Toxicity, Pneumonia." The report indicated the "Assessment/Plan Phenobarbital toxicity, accidental or unintentional,...Epilepsy, unsp (unspecified), not retractable, without status ep (epilepticus), Bacterial pneumonia Patient in is in the office for Transition of Care Visit...Repeat chest x-ray. His phenobarbital level was</p>			

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	<p>elevated yesterday raised and receiving double doses for at least a few days before this. We'll go back to the dose he is supposed to have of 64.2 mg 2 tablets daily and recheck a phenobarbital level on next Monday...." The Plan of Care indicated client D had been in the hospital for "septic with pneumonia" and phenobarbital toxicity when discharged on 12/24/15.</p> <p>-1/13/16 Client D saw the nurse practitioner for a follow-up from the client's ER visit on 1/4/16. Phenobarbital level was ordered for 1/15/16 as client D was to see the Neurologist on 1/19/16. The form indicated "Continue seizure monitoring."</p> <p>-1/20/16 Client D's Keppra (seizure) medication was increased and the client's Phenobarbital was decreased by the Neurologist. An attached 1/20/16 physician's order indicated "phenobarb 32.4 mg (2 tablets) &amp; 1/2 po (by mouth) q (every) d (day) x 2 wks (weeks) then (2 tablets) po q HS (bed time) x 2 wks."</p> <p>An attached 1/20/16 note entitled Medication Change for Phenobarbital and Keppra indicated "[Client D] was seen by [name of Neurologist] today for a routine Neurology checkup. [Name of doctor] would like to taper [client D] off of his</p>			

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	<p>Phenobarbital and increase his Keppra dose." The typed note included documented side effects for Phenobarbital and Keppra medications. The note indicated "...If you notice any of these side effects or any other abnormal issues with [client D] after starting these medication changes or if you have any questions about this training or about any of [client D's] medications please notify the on call nurse and RHM (Residential Home Manager) [staff #1]."</p> <p>Client D's Nurse's Notes indicated the following (not all inclusive):</p> <p>-2/6/15 "This writer/RN (RN #2) received a phone call from DSP (Direct Support Professional) at group home stating [client D] had a 2 minute seizure. No injuries. Staff was directed to follow seizure risk plan. Staff then called again stating [client D] had experienced 2 more seizures. Staff administered Diastat rectally. [Client D] then experienced another seizure. 911 was called...."</p> <p>-2/20/15 "Rec'd (received) call from workshop [client D] had 3 seizures, his VNS/magnet combination did not stop the seizures and workshop nurse stated he was administered rectal Diastat &amp; EMS (emergency medical service) called, per risk plan. [Client D] was transported via</p>			

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	<p>ambulance to [name of hospital]. He has been observed and is scheduled for d/c (discharge) as soon as lab results are known...."</p> <p>-3/4/15 "[Client D] experienced 3 seizures which did not respond to his VNS/magnet and staff administered rectal Diastat. He had another seizure and per protocol staff called 911. He was transported to [name of hospital] ER for evaluation/treatment. While there his electrolytes were out of normal range (sodium 149 (normal 135-145)...." The note indicated client D was admitted to the hospital.</p> <p>-3/24/15 "Staff reported on 3/22/15 [client D] was admitted to the hospital due to seizure activity. He spent Sunday night at the hospital and was discharged Monday evenings with no restrictions...." The note indicated the client's seizure medications were increased.</p> <p>-3/26/15 "Received a phone call from the workshop that [client D] had multiple seizures and was being transported to ER for evaluation...."</p> <p>-3/31/15 "[Client D] was seen today by [name of doctor] to follow up from his ER visit on 3/26 and hospital stay on 3/24, along with medication changes that</p>			

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	<p>took effect on 3/28/15. Residential group home staff had reported changes in [client D's] baseline behavior as well as an unsteady gait. [Name of doctor] wants to keep the Keppra dose the same, but decrease the Klonopin dose...."</p> <p>-4/8/15 Client D saw his Neurologist. The note indicated the nurse asked for the client's Diastat dose be increased due to client D's seizures. The note indicated the Neurologist did not want to increase the dose.</p> <p>-10/22/15 "Rec'd call at approximately 7:30 AM. [Client D] was having seizure activity. Staff indicated he required Diastat and it was effective...."</p> <p>-10/22/15 "Was at group home doing other tasks when staff called writer (RN #1) to the living room area where [client D] was having another seizure. Followed all seizure plans, Diastat was ineffective and 911 was called. He was transported to [name of hospital] where he was for intractable (seizures that fail to come under control with treatment) seizures. He was released to this writer and while being transported home, he began to have another grand mal seizure in the car with this writer. Writer secured safety and turned around. Called [name of hospital] and explained recurrent seizures.</p>			

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	<p>EMT/Paramedic met writer at ER doors and [name of hospital] staff removed [client D] from writer's car and transported him via gurney to ER for evaluation and treatment. He was given IV anti seizure meds and eventually he was admitted to [name of hospital] ICU for observation."</p> <p>-10/28/15 Client D saw his Neurologist due to his recent seizure activity. The note indicated "...[Name of Neurologist] determined the seizures may have been due to [client D] having flu-like symptoms...."</p> <p>-12/8/15 "[Client D] was seen by [name of CNP] (Certified Nurse Practitioner) for recent fall, lethargy and poor balance. No med changes, Negative evaluation. Labs ordered...."</p> <p>-12/11/15 "[Client D] is very lethargic and unsteady on his feet. He is having difficulty forming words and keeping eye contact. He does recognize staff and responds with yes/no answers. Called [name of doctor's] office and to alert them of [client D's] lethargy...will find out the lab results then she will call back with information and any orders needed...."</p> <p>-12/11/15 "Labs abnormal =</p>			

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	<p>Phenobarbitol (sic) &gt; 80 mcq/ml (normal range 15-40 mcq/ml). Contacted neurologist [name of doctor] regarding phenobarbitol (sic). Orders rec'd to STOP phenobarbitol NOW and recheck level Monday 12/14/15...."</p> <p>-12/13/15 "Staff informed writer (RN #1) [client D's] more lethargic (sic) B/P (blood pressure) this morning was 106/62. Instructed staff to repeat B/P every 2 hrs (hours) and report any abnormal B/P to writer. In the mid afternoon (approximately 1:30pm) staff reported B/P 79/49 and this writer contacted RHM [staff #1] and arrangements were made to take [client D] to ER for evaluation...Upon evaluation he was determined to have left lung pneumonia and septic. He was admitted to ICU."</p> <p>-12/14/15 Client D remained in the hospital "...Non-responsive to staff, but moans in response to movement of his limbs by writer (RN #1)."</p> <p>-12/18/15 "[Client D] is awake and alert. He remains in the hospital but has been moved to a medical bed...."</p> <p>-12/21/15 "Spoke with nurse at [name of hospital] regarding [client D]. She stated he no longer has IV fluids, no</p>			

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	<p>catheter, no supplemental oxygen. His vitals signs are stable. Therapy is working with him for strengthening...."</p> <p>-1/1/16 "Staff called around 9 AM to report that [client D's] B/P (blood pressure) was low 88/65. Writer (LPN #1) called [name of doctor] to report. [Name of doctor] stated it could be due to the Carvedilol (hypertension-beta blocker) that was prescribed to him while he was in the hospital. [Name of doctor] asked that I go assess [client D]. Upon assessment B/P was 90/62, P (pulse): 60, R (respiration): 18, T (temperature): 94.0 temporal. [Client D] felt very cold to the touch. [Client D] was fairly lethargic. [Name of doctor] was called back and vitals were reported. [Name of doctor] stated he wanted the Carvedilol stopped and wanted [client D] monitored closely tonight and stated if his B/P dropped lower than 80/60 to take him to the ER (emergency room). Staff was instructed to check B/P and Pulse every 2 hours. Medication was stopped on the MAR and medication was pulled from the medication cabinet."</p> <p>-1/3/16 "Staff reported [client D] continues to be lethargic and vitals are 86/68, 84, 16 and 97.5 F (Fahrenheit). [Client D] can squeeze my hands equally in strength but he is weaker than his usual</p>			

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	<p>grips. He is appropriately answering yes/no questions. He is holding his head erect and appears somewhat sleepy. Upon review of records, it appears [client D] has received 4 64.8 mg tablets of phenobarbital on both January 1st (first) and January 2nd, @ (at) 8 pm. Called [name of doctor] to request directive. Awaiting return call." The entry was written by RN #1.</p> <p>-1/3/16 "[Name of doctor] returned call. Informed him of vitals and current level of function. Also informed him of [client D] receiving (4) 64.8 mg tablets instead of (2) 64.8 mg tablets on January 1st and January 2nd. [Name of doctor] stated to HOLD 8 pm phenobarbitol (sic) tonight. Also obtain phenobarbitol (sic) blood level Monday January 4, 2016. Once phenobarbitol (sic) blood level is obtained [name of doctor] will decide if staff are to hold Monday dose or administer the med. Staff have been directed to document ounces of fluid consumed every 2 hours and to obtain vitals every 2 hours. Will continue to observe."</p> <p>-1/4/16 Facility staff took client D to get the Phenobarbital lab. The note indicated staff was concerned about client D's "level of consciousness that he may need to be seen in the ER. [Client D] was</p>			

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	<p>taken to the ER around 230pm..." The note indicated the ER doctor checked client D and indicated it would take 24 hours for the client's Phenobarbital level to come back. The note indicated client D was sent home with instructions to monitor client D, and to hold the client's 8 PM Phenobarbital dose.</p> <p>-1/5/16 "[Name of doctor] gave a verbal order to hold phenobarbital until Thursday evening...Writer (LPN #1) put a hold on phenobarbital until Thursday (1/7/16)."</p> <p>-1/9/16 "Writer (LPN #1) was notified at 7:30am that [client D] had been taken to the ER for a series of cluster seizures that lasted for about 30 mins (minutes). Upon arrival at [name of hospital] ER...[name of doctor] came in and asked what had happened, [staff #2] explained what happened. Writer informed [name of doctor] that [name of doctor] had put a hold on the phenobarbital (sic) until Thursday (1-7-16) @ 8 pm when was to be resumed. [Staff #2] spoke up and stated it had not been resumed on Thursday (1-7-16). Upon looking at the MAR it appears that staff continued to hold med through Friday (1-8-16). Writer told [name of doctor] she was unclear as to why medication was not</p>			

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	<p>passed...." The note indicated client D was given an intravenous Phenobarbital and then sent back to the group home.</p> <p>-1/9/16 (6:00 PM) The facility's nurse was called by staff as client D had "...been seizing for about 10 min. I (LPN #1) told [staff #2] I was on my way. [Staff #2] asked if it was ok to administer Diastat (rectal medication for seizures). Writer told her to follow protocol and Dr. (doctor) orders. [Staff #2] stated his Dr. orders stated to administer after 10 minutes of seizure activity. [Staff #2] administered rectal Diastat at 6:12 pm. When writer arrived [client D] was awake but not alert. [Client D] had several small tremors and [staff #2] swiped VNS (Vagal Nerve Stimulator) everytime, each time VNS was swiped [client D] stopped seizing...." The note indicated the nurse attempted to call client D's doctor 3 times with no response/return call from the doctor.</p> <p>-1/11/16 "late entry for 1/5/16 [Client D] was taken to [name of doctor] for a follow up from his hospital stay. [Name of doctor] gave us results of phenobarbital level -60- was the level... [Name of doctor] gave an order to hold pheno (Phenobarbital) until Jan (January) 7th due to being toxic to his phenobarbital...."</p>			

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	<p>-1/13/16 Client D saw the nurse practitioner. The note indicated client D's Phenobarbital level was "...49 right now...." The note indicated the lab was to be repeated on 1/15/16.</p> <p>-undated entry "At 2:30 pm writer (staff #1) received a phone call from [name of nurse at doctor's office]. [Name of nurse] stated that [client D's] lab results came in from A.M. draw his phenobarbital level was up to 50.9. Nurse instructed writer to decrease from 129.6 mg of phenobarbital @ 8 pm to 32.4 mg x (times) 3 @ 8 pm totaling 97.2 mg. Medication was called into [name of pharmacy] by [LPN #1]. 1st training done by house manager. Mars corrected by nurse. [Name of doctor's office nurse] also instructed writer to take labs again in two weeks."</p> <p>-1/20/16 "[Client D] was seen for a follow up from being hospitalized for pneumonia and seizure activity. the (sic) results of this appointment are as follows: 1) taper off of phenobarbital. [Client D] will take 2 1/2 tablets by mouth @ bedtime for two week starting 1-21-16 &amp; ending on 2-4-16 then he will take two tablets by mouth once a day at bedtime for 2 weeks start date will be 2-5-16 &amp; end date will be 2-19-16. 2) [Name of Neurologist] wants to increase his Keppra</p>			

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	<p>dose to 750 mg by mouth twice a day @ 8 am &amp; 8 pm. Start date will be 1-21-16...."</p> <p>Client D's record indicated the facility neglected to document client D's seizure activities on a seizure record as client D did not have a seizure record for 2015 and 2016.</p> <p>Client D's 2/25/15 Individual Support Plan (ISP) and/or record indicated the client's interdisciplinary team (IDT) neglected to meet and/or address client D's increased seizure activity as there were no IDT notes documented in the client's record. Client D's 2/25/15 ISP and/or 2/25/15 Seizure Risk Management Plan (RMP) indicated the facility neglected to address and/or include status epilepticus seizures. Client D's ISP indicated the facility neglected to address/include a risk plan for Hypokalemia and Phenobarbital Toxicity (prior to client D's doctor tapering off). The facility neglected to ensure the facility's nurse assessed client D after he was discharged from the hospital on 12/24/15 to ensure continuity of care, and to put additional nursing measures in place to monitor the client's toxic Phenobarbital level and/or health.</p> <p>Interview with staff #3 on 1/13/16 at 4:53</p>			

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	<p>PM indicated client D was in the hospital due to seizures in December 2015. Staff #3 stated client D had "clusters" of seizures.</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04 PM indicated client D had a seizure diagnosis. LPN #1, administrative staff #1 and the DRS stated client D had been in the hospital and was discharged on 12/24/15 for Pneumonia and "Phenobarbital toxicity." The DRS stated a medication error was made in regard to client D's Phenobarbital where the client was "double dosed" after his hospital discharge from 12/24/15 to 1/2/16. The DRS indicated RN #1 transcribed the order on the MAR wrong and facility staff #1 caught the error on 1/4/16. DRS and LPN #1 indicated RN #1 did not assess client D after his hospital discharge on 12/24/15. LPN #1 and the DRS indicated client D should have been assessed by a nurse as the client was in the hospital due to "Sepsis Pneumonia and Phenobarbital Toxicity." When asked how often client D's potassium level was monitored, LPN #1 indicated she was not sure. When asked if client D had a risk plan for Hypokalemia, LPN #1 stated "No." LPN #1 indicated she was not aware the hospital had diagnosed</p>			

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	<p>client D with Hypokalemia. When asked if client D had a risk plan for Status Epilepticus, LPN #1 and the DRS indicated client D's seizure risk plan did not specifically include/address Status Epilepticus. LPN #1 and the DRS stated facility staff were to use client D's Diastat when the client had "three or more cluster of seizures and if don't work call 911." LPN #1 indicated client D also had a VNS which facility staff were to swipe with a magnet when the client had a seizure. The DRS and administrative staff #1 indicated client D's IDT had met by email, but the client's record did not include any documentation of the IDT's meeting. When asked if client D's seizure plan had been updated, LPN #1 and the DRS indicated client D's risk plan had not been updated.</p> <p>LPN #1 and the DRS indicated client D's Neurologist recently decreased client D's Phenobarbital to take the client off the medication. LPN #1 indicated the Neurologist indicated client D could become toxic on the Phenobarbital again.</p> <p>The facility's policy and procedures were reviewed on 1/20/16 at 1:30 PM. The facility's undated policy entitled Prohibition of Violation of Individual Rights indicated "In order to protect the general welfare of persons served, Bona Vista Programs strictly prohibits the</p>			

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	<p>abuse of any form, neglect, exploitation or mistreatment of an individual...." The facility's undated policy defined neglect as "Failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual."</p> <p>3. The facility's policy and procedures were reviewed on 1/20/16 at 1:30 PM. The facility's undated policy indicated "...Reporting It is the responsibility of any employee who possess knowledge of an alleged case of neglect, battery, exploitation of violation of individual's rights to report it immediately, verbally and/or in writing to the President, or if the President is unavailable, the Director, Human Resources." The facility's policy indicated "...The main objective or our investigation is to provide a thorough, comprehensive, and factual basis for determining necessary and/or needed corrective actions to ensure that we are providing a safe environment for the individuals that we serve." The facility's undated policy indicated the facility would make recommendations and/or include any "necessary transfers/training" regarding the facility's corrective action section of the its investigation.</p> <p>The facility failed to ensure its staff reported an allegation of staff to client</p>			

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W 0153  Bldg. 00	<p>abuse immediately to the administrator when the incident occurred for client D. Please see W153.</p> <p>The facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, D and H. Please see W154.</p> <p>The facility failed to put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to prevent significant medication errors for client D. The facility failed to take appropriate corrective action in regard to retraining staff in regard to client C and D's falls, and in regard to an allegation of staff to client abuse involving clients B and H. Please see W157.</p> <p>This federal tag relates to complaint #IN00185316.</p> <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.</p>						

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	<p>Based on interview and record review for 1 of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure its staff reported an allegation of staff to client abuse immediately to the administrator when the incident occurred for client D.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's 12/2/15 reportable incident report indicated a facility staff reported staff #5 "...tipped [client D] out of his chair (wheelchair) so he would get up...." The reportable incident report indicated staff #5 was "immediately suspended" and investigation initiated on 12/2/15.</p> <p>The facility's 12/9/15 investigation indicated the allegation of staff to client abuse occurred a month prior to staff making the report.</p> <p>Interview with administrative staff #1 and the Director of Residential Services (DRS) on 1/21/16 at 3:04 PM indicated the allegation of staff to client abuse was not reported to the administrator timely. The DRS stated "Staff did not report</p>	W 0153	<p><b>W153</b> <b>Finding(s):</b> <b>1. "Based on interview and record review for 1 of 10 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."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure the facility staff report all allegations of abuse, neglect, and/or injuries of unknown source immediately to the administrator</b> 1. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight. 2. To further ensure competency and understanding all staff located in the home will be retrained quarterly on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>	03/16/2016	

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W 0154 Bldg. 00	<p>when it occurred. It occurred a month ago." The DRS stated "[Staff #5] written up for late reporting."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 3 of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients B, D and H.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-1/4/16 "[Client D] was discharged from the hospital on 12/24/2015. His MAR (Medication Administration Record) had</p>	W 0154	<p><b>W154</b> <b>Finding(s):</b> 1. "Based on interview and record review for 3of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed,the facility failed to conduct a thorough investigation in regard to theallegations of abuse, neglect and/or injuries of unknown source for clients B,D, and H."</p> <p><b>CorrectiveAction(s):</b> To ensure that established agency policies andprocedures for investigations are being implemented, correctivemeasures/actions are being implemented and executed as written in regard toretraining staff for all clients. To ensure that established agency policiesand procedures for conducting thorough investigations are being implemented forall allegations of abuse, neglect and/or</p>	03/16/2016

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	<p>previously had doctors orders for Phenobarb (Phenobarbital-seizures) 64.8mg (milligrams) tab (tablet), take 2 tablets by mouth every night at bedtime on it. Upon discharge from the hospital on 12/24/2015 the doctor's discharge orders were 32.4mg tab take 129.6mg oral at bedtime. The Residential Nurse altered the MAR at the group home, to match the current doctor orders, she transcribed the order incorrectly on 12/24/2015 and wrote Phenobarb 129.6mg (64.8 mg) take 4 tablets by mouth every night at bedtime. [Client D] received a double dose of his Phenobarbital from 12/24/2015 to 1/2/2016. The Residential House Manager found the error on 1/4/2016, [client D] was taken to the ER (emergency room), labs were drawn, his doctor was notified, he was discharged and sent back to the group home. [Client D] had a follow up appointment with his GP (General Practice) doctor today. His Phenobarbital level from the labs taken yesterday were within normal limits. Doctor is holding the Phenobarbital until Thursday as a precaution and ordered a repeat lab draw on Monday, 1/11/2016. The Residential Nurse making the error was immediately suspended and an investigation was started. Plan to Resolve [Client D] will continue to be monitored</p>		<p><b>injuries of unknown source.</b></p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of Training form will be completed for all trainings on corrective actions/measures for the corrective and be submitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Residential Director of Quality Assurance and Social Service Coordinator, and the Social Service Coordinator will be trained on the newly established</p>	

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	<p>for any adverse affect of receiving too much Phenobarbital...."</p> <p>The facility's 1/12/16 Residential Services Investigation Checklist indicated the facility conducted an investigation in regard to client D's significant medication error. The facility's 1/12/16 investigation indicated the nurse who made the error was an RN (Registered Nurse). The facility's investigation indicated facility staff, who worked in the group home, were told to administer 4 tablets of client D's Phenobarbital by the nurse and/or other staff as instructed. The facility's investigation indicated "...12/11/15 The Phenobarb was stopped by the doctor due to [client D] being lethargic. He was taken to the hospital on 12-13-15, and was found to be septic. On 1/1/16 Carvedilol was stopped per doctors (sic) orders because [client D's] blood pressure was so low. On 1/1/16 it was noted that [client D] had received 4 64.8mg tabs of Phenobarb on both 1/1 and 1/2...On January 4th, it was brought to the attention of the Director of Residential Services that person served [client D] had been receiving a double dose of his medication Phenobarbital for ten days. [RN #1], the nurse that transcribed the wrong dosage, was immediately suspended pending an</p>		<p>investigation process. Record of Training forms will becompleted following staff trainings and will be submitted to the ResidentialDirector for administrative oversight.</p> <p>3.Allstaff located in the home will be retrained on reportable incidents, theprocedure for reporting, and the abuse, neglect, and exploitation policy.Record of Training forms will be completed following staff trainings and willbe submitted to the Residential Director for administrative oversight.</p>				

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	<p>investigation...When [client D] was released from the hospital the doctor had prescribed him to take 4 tabs at 32.4mg per pill at bed time every night. However, [client D] was already on the medication, so the pharmacy just continued with the same pills. The pills he was already on of the medication had 64.8mg per pill. The house manager stated that his Phenobarbitol (sic) had always been 64.8mg per tab. During the investigation, the house manager stated that [RN #1] had changed the Narcotic count record to say that staff were to administer 4 tabs of the Phenobarbitol (sic) instead of the 2 tabs that were prescribed. The house manager stated that she believed [RN #1] instructed the staff to administer 4 of the pills because she was going with what the hospital wrote the prescription for. The house manager stated that [RN #1] checked in the medications when they received them from the pharmacy, but she did not catch the error then. The house manager stated that she found the error when she went to the home and looked through all of the paperwork after another staff member had called her and told her that she felt like [client D's] medications needed to be looked at. The Team Lead from the house stated that she was passing meds on January 2nd (second), when she thought there was an issue. She stated</p>			

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	<p>that she gave [client D] two of the pills at first, but then ended up giving him a total of 4 of the pills because on the MAR it stated to administer 4 pill (sic). She stated that all of the staff before her had also given him 4 pills at every 8pm med (medication) time per the MAR. She stated that she still felt that it wasn't right, so she contacted the nurse. She stated that the nurse then told her to go with what the pharmacy sent as the dose...[RN #1], the nurse, stated that she instructed the staff to administer 4 pills per dose because the instructions from the hospital stated to administer 4 pills at 32.4mg were to be administered to amount to 129.6. She stated that the pharmacy gave them the other amount of medication in the pills. She stated that she first realized the error on Sunday when she went over to the home to assess [client D] due to him having low blood pressure. She stated that she got the pills out and then got her phone out and compared the pills to one another. She stated that she got the stickers out from the prescription and thought that the staff was administering the medication wrong. She stated that she then called the doctor to inform him of the situation. She stated the doctor informed her to hold the 8pm dose for the day, and then to take [client D] to get his labs done on Monday. She stated that she was the one that had transcribed the</p>			

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	<p>instructions for the staff to follow starting on December 24th to January 2nd. She stated that she had noticed signs that it may have been affecting him because he was lethargic and not himself on Sunday....Due to the medication error being significant, and lasting for ten days it is being recommended that the nurse from the group home be terminated...Also, all of the staff from the group home will be retrained on medication administration."</p> <p>Staff #1's 1/4/16 Investigation Interview Form also indicated client D was not given the correct dose of his Metronidazole (antibiotic) which was to be 500 mg two times a day but client D had only received Metronidazole 250 mg two times a day.</p> <p>RN #1's 1/5/16 Investigative Interview Form indicated she knew he was to receive the 32.4 mg tablets of Phenobarbital versus the 64.8 mg tablets. RN #1's statement indicated she was the one who had transcribed the order onto the MAR. RN #1's statement indicated "...The pharmacy gave us the other amount of medication...." RN #1's statement indicated she was the one who had realized the error on Sunday when she went to the group home to assess client D. RN #1's statement indicated she</p>			

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	<p>called the doctor once she realized staff had been giving the wrong medication.</p> <p>The facility's 1/12/16 investigation indicated the facility attached client D's hospital records from his 12/13/15 hospitalization. Client D's 12/24/15 Patient Instructions for: Client D indicated "Discharge Diagnosis: Community acquired pneumonia (J18.9)." Client D's discharge summary indicated the client was discharged on a pureed diet with thickened liquids. The discharge summary indicated client D was treated for "...Left sided Pneumonia...Septic Shock...Seizure Disorder...." Client D's 12/24/15 discharge summary indicated client D was to receive the following medications (not all inclusive): "...Metronidazole 250 mg tab 500 mg PO (by mouth) twice a day twice a day Phenobarbital 32.4 mg tab 129.6 oral at bedtime...."</p> <p>An attached typed Medication Change note indicated "[Client D's] phenobarbital has been increased to 129.6 mg at 8 pm (sic) He is to receive 4 tablets at 8pm starting 12/24/2015. Please observe for over sedation (excessive drowsiness, difficulty with coordination, slurred speech) and report to the Residential Nurse on duty immediately." The</p>			

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	<p>medication change note neglected to specifically indicate the pill dosage of the 4 tablets the client was to receive as the note implied client D was to receive 4 tablets of 129.6 mg tablets.</p> <p>An attached client D's December 2015 MAR indicated under the medication sections: "Phenobarb 129.6 mg Take 4 tablets by mouth every night at bedtime (4 tabs)...*Give 4 tablets* each tablet 32.4 use 4 tabs to equal 129.6 mg" was written where staff sign their initials. The facility's investigation indicated the facility failed to include documentation from the pharmacy on what Phenobarbital dosage was sent to the group home. Client D's December 2015 MAR indicated client D received Metronidazole 250 mg 1 tablet twice a day (half the dose of what was ordered) for 10 days. The facility's investigation failed to address the medication error involving client D's antibiotic. The facility's 1/12/16 investigation indicated the facility failed to document/conduct a thorough investigation in regard to the 1/7/16 medication error (allegation of neglect) with client D's Phenobarbital not restarting as ordered.</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04</p>			

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	<p>PM indicated client D had a seizure diagnosis. Administrative staff #1 and the DRS indicated there had been 2 medication errors in regard to the client's Phenobarbital. LPN #1 indicated she did not know why the staff did not restart client D's Phenobarbital on 1/7/16 as ordered. LPN #1 stated "I told them what to do but staff did not follow." Administrative staff #1 and the DRS indicated the facility conducted an investigation in regard to client D's medication errors.</p> <p>2. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's 12/2/15 reportable incident report indicated a facility staff reported staff #5 "...tipped [client D] out of his chair (wheelchair) so he would get up...." The reportable incident report indicated staff #5 was "immediately suspended" and investigation initiated.</p> <p>The facility's 12/9/15 follow-up to the 12/2/15 reportable incident report indicated the facility "partially substantiated" the allegation of abuse. The follow-up report indicated staff #5 would be returned to work and be "Retrained on Person Served Rights" and on "Proper ways to prompt Individual to</p>			

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	<p>achieve desired tasks."</p> <p>The facility's 12/9/15 investigation indicated 3 facility staff had witnessed staff #5 tip client D's wheelchair to get the client up. The facility's investigation indicated client D indicated no one had tipped him out of his wheelchair. The facility's investigation also indicated staff #5 was interviewed and staff #5 indicated she did not tip client D out of his wheelchair. The facility's investigation indicated staff #5 stated "...She rocks chair to get client up..." The facility's investigation indicated other staff had admitted to rocking the client's wheelchair to assist the client to stand/get up. The facility's investigation indicated no other clients were interviewed, besides client D, in regard to the staff to client allegation of abuse. The facility's 12/9/15 investigation also indicated a facility staff stated staff #5 was "yelling" at client D and client B. The facility's 12/9/15 investigation did not specifically investigate the staff's allegation of verbal abuse toward clients B and D.</p> <p>Interview with administrative staff #1 and the DRS on 1/21/16 at 3:04 PM indicated the allegation of staff to client abuse was investigated. The DRS and administrative staff #1 indicated they had facility staff demonstrate what staff #5</p>						

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	<p>did. Administrative staff #1 and the DRS stated the staff made a "movement (shaking) of chair to get him out of chair." The DRS and administrative staff #1 indicated client D was not actually "tipped out of chair." Administrative staff #1 and the DRS stated the allegation of physical abuse was "partially substantiated." The DRS indicated facility staff were to be retrained in regard to assisting the client to get out of his wheelchair. When asked if other clients were interviewed in regard to the allegation of abuse, administrative staff #1 and the DRS indicated no other clients were interviewed. When asked if the facility investigated the allegation of verbal abuse made against staff #5, administrative staff #1 and the DRS stated "Not really addressed."</p> <p>3. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's 11/19/15 reportable incident report indicated client B was pushed by client H on the shoulders. The reportable incident report indicated client H "attempted to claw [client B] in the face." The reportable incident report indicated the facility did not document and/or conduct an investigation in regard to the client to client aggression/abuse incident</p>			

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W 0157 Bldg. 00	<p>as no investigation was attached.</p> <p>Interview with administrative staff #1 and the DRS on 1/21/16 at 3:04 PM indicated the facility's owned day program should have conducted an investigation in regard to the above mentioned client to client aggression/abuse incident involving clients B and H. The DRS stated "I don't have that investigation." The DRS and/or administrative staff #1 did not provide any additional documentation of an investigation.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 4 of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure the facility put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to prevent significant medication errors for client D. The facility failed to take appropriate corrective action in regard to retraining</p>	W 0157	<p><b>W157</b> <b>Finding(s):</b> <b>1. "Based on interview and record review for 4 of 10 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure the facility put corrective actions/measures in place to ensure staff were retrained, and to monitor staff/nurses to</b></p>	03/16/2016

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	<p>staff in regard to client C and D's falls, and in regard to an allegation of staff to client abuse involving clients B and H.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-1/4/16 "[Client D] was discharged from the hospital on 12/24/2015. His MAR (Medication Administration Record) had previously had doctors orders for Phenobarb (Phenobarbital-seizures) 64.8mg (milligrams) tab (tablet), take 2 tablets by mouth every night at bedtime on it. Upon discharge from the hospital on 12/24/2015 the doctor's discharge orders were 32.4mg tab take 129.6mg oral at bedtime. The Residential Nurse altered the MAR at the group home, to match the current doctor orders, she transcribed the order incorrectly on 12/24/2015 and wrote Phenobarb 129.6mg (64.8 mg) take 4 tablets by mouth every night at bedtime. [Client D] received a double dose of his Phenobarbital from 12/24/2015 to</p>		<p><b>prevents significant medication errors for client D. The facility failed to take appropriate corrective action in regard to retraining staff in regard to client C and D's falls, and in regard to an allegation of staff to client abuse involving client B and H."</b></p> <p><b>Corrective Action(s):</b> To ensure that established agency policies and procedures for investigations are being implemented, corrective measures/actions are being implemented and executed as written in regard to retraining staff for all clients. To ensure that established agency policies and procedures for conducting thorough investigations are being implemented for all allegations of abuse, neglect and/or injuries of unknown source.</p> <p>1. All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. All investigations include appropriate corrective action and that all corrective actions/measures are implemented in regards to retraining staff for clients. To ensure that all corrective actions/measures are implemented, a Record of</p>		

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	<p>1/2/2016. The Residential House Manager found the error on 1/4/2016, [client D] was taken to the ER (emergency room), labs were drawn, his doctor was notified, he was discharged and sent back to the group home. [Client D] had a follow up appointment with his GP (General Practice) doctor today. His Phenobarbital level from the labs taken yesterday were within normal limits. Doctor is holding the Phenobarbital until Thursday as a precaution and ordered a repeat lab draw on Monday, 1/11/2016. The Residential Nurse making the error was immediately suspended and an investigation was started. Plan to Resolve [Client D] will continue to be monitored for any adverse affect of receiving too much Phenobarbital...."</p> <p>The facility's 1/12/16 Residential Services Investigation Checklist indicated the facility conducted an investigation in regard to client D's significant medication error. The facility's 1/12/16 investigation indicated the nurse who made the error was an RN (Registered Nurse). The facility's investigation indicated facility staff, who worked in the group home, were told to administer 4 tablets of client D's Phenobarbital by the nurse and/or other staff as instructed. The facility's</p>		<p>Training form will be completed for all trainings on corrective actions/measures for the corrective and resubmitted to the Social Service Coordinator for review. The Social Service Coordinator will take a copy of the Record of training completed for the training and attached it to the investigation to ensure completion. The investigations will be reviewed weekly by the Residential Director to ensure trainings have been completed in accordance to the implemented corrective actions/measures.</p> <p>2. To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Individual Disabilities Professionals, Nurses, Residential Director of Quality Assurance and Social Service Coordinator, and the Social Service Coordinator will be trained on the newly established investigation process. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>3. All staff located in the home will be retrained on reportable incidents, the procedure for reporting, and the abuse, neglect, and exploitation policy. Record of Training forms will be completed following staff trainings and will be submitted to the Residential</p>	

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	<p>investigation indicated "...12/11/15 The Phenobarb was stopped by the doctor due to [client D] being lethargic. He was taken to the hospital on 12-13-15, and was found to be septic. On 1/1/16 Carvedilol was stopped per doctors (sic) orders because [client D's] blood pressure was so low. On 1/1/16 it was noted that [client D] had received 4 64.8mg tabs of Phenobarb on both 1/1 and 1/2...On January 4th, it was brought to the attention of the Director of Residential Services that person served [client D] had been receiving a double dose of his medication Phenobarbital for ten days. [RN #1], the nurse that transcribed the wrong dosage, was immediately suspended pending an investigation...." The facility's 1/12/16 investigation indicated "...When [client D] was released from the hospital the doctor had prescribed him to take 4 tabs at 32.4mg per pill at bed time every night. However, [client D] was already on the medication, so the pharmacy just continued with the same pills. The pills he was already on of the medication had 64.8mg per pill. The house manager stated that his Phenobarbital (sic) had always been 64.8mg per tab...." The facility's investigation indicated "...[RN #1], the nurse, stated that she instructed the staff to administer 4 pills per dose because the instructions from the hospital</p>		<p>Director for administrative oversight.</p> <p>-</p>				

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	<p>stated to administer 4 pills at 32.4mg were to be administered to amount to 129.6. She stated that the pharmacy gave them the other amount of medication in the pills. She stated that she first realized the error on Sunday when she went over to the home to assess [client D] due to him having low blood pressure. She stated that she got the pills out and then got her phone out and compared the pills to one another. She stated that she got the stickers out from the prescription and thought that the staff was administering the medication wrong. She stated that she then called the doctor to inform him of the situation. She stated the doctor informed her to hold the 8pm dose for the day, and then to take [client D] to get his labs done on Monday. She stated that she was the one that had transcribed the instructions for the staff to follow starting on December 24th to January 2nd. She stated that she had noticed signs that it may have been affecting him because he was lethargic and not himself on Sunday....Due to the medication error being significant, and lasting for ten days it is being recommended that the nurse from the group home be terminated...Also, all of the staff from the group home will be retrained on medication administration."</p> <p>Staff #1's 1/4/16 Investigation Interview</p>			

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	<p>Form also indicated client D was not given the correct dose of his Metronidazole (antibiotic) which was to be 500 mg two times a day but client D had only received Metronidazole 250 mg two times a day.</p> <p>An attached 12/24/15 Record Of Training Session, by RN #1, indicated "Title of Session: [Client D's] Medication Change Subject: phenobarbital 32.4 mg tablets-Increased Dose to 129.6 mg." The facility did not provide any additional training and/or documentation in regard to all facility staff being retrained in regard to Core A and B (state curriculum for medication administration) medication administration.</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04 PM indicated client D had a seizure diagnosis. Administrative staff #1 and the DRS indicated there had been 2 medication errors in regard to the client's Phenobarbital. LPN #1 indicated she did not know why the staff did not restart client D's Phenobarbital on 1/7/16 as ordered. LPN #1 stated "I told them what to do but staff did not follow." Administrative staff #1 and the DRS indicated RN #1 was terminated due to</p>			

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	<p>the 12/24/15 to 1/2/16 medication error with client D's double dosing of the Phenobarbital on 1/10/16. LPN #1 indicated she had trained staff on administering client D's medication changes and orders. LPN #1 indicated she would look for the documented training, but did not provide any additional training documentation. Administrative staff #1 and the DRS stated "Oversight was missing after the first error." Administrative staff #1 indicated the facility did not put any additional measures/system in place to ensure the nurses transcribed orders correctly and/or staff administered medications as ordered. Administrative staff #1 indicated they had spoken with LPN #1 in regard to what the facility expected. Administrative staff #1 and the DRS stated "She (nurse) will have to be monitored and expectations made with staff." The facility did not provide any additional documentation in regard to the recommended retraining of staff in Core A and B medication administration and documentation.</p> <p>2. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's 12/2/15 reportable incident report indicated a facility staff reported</p>				

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	<p>staff #5 "...tipped [client D] out of his chair (wheelchair) so he would get up...."</p> <p>The facility's 12/9/15 follow-up to the 12/2/15 reportable incident report indicated the facility "partially substantiated" the allegation of abuse. The follow-up report indicated staff #5 would be returned to work and be "Retrained on Person Served Rights" and on "Proper ways to prompt Individual to achieve desired tasks."</p> <p>Interview with administrative staff #1 and the DRS on 1/21/16 at 3:04 PM indicated the allegation of staff to client abuse was investigated. The DRS and administrative staff #1 indicated they had facility staff demonstrate what staff #5 did. Administrative staff #1 and the DRS stated the staff made a "movement (shaking) of chair to get him out of chair." The DRS and administrative staff #1 indicated client D was not actually "tipped out of chair." Administrative staff #1 and the DRS stated the allegation of physical abuse was "partially substantiated." The DRS indicated facility staff were to be retrained in regard to assisting the client to get out of his wheelchair. The DRS indicated she would check to when facility staff were retrained. The DRS and/or administrative staff #1 did not provide</p>			

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	<p>any additional information/documentation of the recommended training/corrective action.</p> <p>3. The facility's reportable incidents and investigations were reviewed on 1/19/16 at 3:17pm. The facility's reportable incidents indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> <li>- 1/1/16: "Staff was assisting [Client D] to the restroom while he was in his wheelchair. Staff was reposition (sic) the wheelchair to navigate through the bathroom door way when [client D] lost his balance and hit his left chin and lip on the handle of the wheelchair."</li> <li>- 1/8/16: "[Client C] was eating lunch at the kitchen table and stood up and reached for his wheelchair. He missed his wheelchair and fell on the floor hitting his head on the kitchen counter." The 1/13/16 investigation attached to this incident indicated staff #4 was holding onto the wheelchair when client C fell.</li> </ul> <p>The facility's reportable incident reports and/or investigations did not indicate the facility completed any corrective action in regard to retraining staff on transfer safety.</p> <p>An interview with the Director of</p>			

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W 0249  Bldg. 00	<p>Residential Services (DRS) and Administrative staff #1 was conducted on 1/21/16 at 3:04pm. When asked if any corrective action was implemented the DRS stated "I'll have to check". The facility was unable to provide any additional documentation for review.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview for 1 of 4 sampled clients (C), the facility failed to implement client C's Behavior Support Plan in regards to the use of his protective helmet.</p> <p>Findings include:</p> <p>During the 1/13/16 observation period from 3:30pm until 4:55pm client C wore</p>	W 0249	<p><b>W249</b></p> <p><b>Finding(s):</b></p> <p><b>1. "Based on observation, interview, and record review for 1 of 4 sampled clients ©, the facility failed to implement client C's Behavior Support Plan in regards to the use of his protective helmet."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure that client C's Behavior Support Plan (BSP) is being implemented and followed in accordance to</b></p>	03/16/2016			

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	<p>his protective helmet while sitting at the kitchen table. Client C was sitting in a chair and made several attempts to stand up from his chair. Staff #5 went and got a helmet and placed it on client C's head. The helmet had a chin strap that was held on by tape and would not stay secured around client C's chin. Client C was sitting at the kitchen table having a snack and a drink. Client C was not banging his head at this time. At 4:15pm client C would take his helmet off and throw it on the floor and staff would pick it up and place it back on his head.</p> <p>Client C's record was reviewed on 1/20/16 at 1:26pm. Client C's May 2015 BSP (Behavior Support Plan) indicated "[Client C] wears a helmet when he begins banging his head. Staff will put the helmet on [client C's] head and fasten the strap. Staff will remove the helmet when he has stopped banging his head. [Client C] also wears his helmet when there are corners or hard objects he could hit his head on during periods of agitation. His helmet is removed after he has calmed and out of danger."</p> <p>Interview with the Director of Residential Services (DRS) and Administrative staff #1 was conducted on 1/21/16 at 3:04pm. When asked when client C should wear his helmet, the DRS stated "it's in his</p>		<p><b>the use of his protective helmet:</b></p> <p>1.All staff located in the home will be retrained,by the Qualified Intellectual Disabilities Professional (QIDP), on client C'sBehavior Support Plan (BSP) in regards to the use and implementation of wearinghis protective helmet. Record of Training forms will be completed followingstaff trainings and will be submitted to the Residential Director foradministrative oversight.</p>		

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W 0263  Bldg. 00	<p>plan."</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client C), the facility failed to obtain written informed consent from client C's guardian for client C's restrictive program.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 1/20/16 at 1:26pm. Client C's May 2015 BSP (Behavior Support Plan) indicated client C has the following restrictions: 1. "[Client C] wears a helmet when he begins banging is head. Staff will put the helmet on [client C's] head and fasten the strap. Staff will remove the helmet when he has stopped banging his head. [Client C] also wears his helmet when there are corners or hard objects he could hit his head on during periods of agitation. His helmet is removed after he has calmed and out of danger." 2. "[Client C] at times becomes extremely agitated...When</p>	W 0263	<p><b>W263</b></p> <p><b>Finding(s):</b></p> <p><b>1. "Based on record review and interview of 1 of 4 sampled clients (client C), the facility failed to obtain written informed consent from client C's guardian for client C's restrictive programs."</b></p> <p><b>-</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure that written informed consent is obtained from client C's guardian for his restrictive programs:</b></p> <p>1. The Qualified Intellectual Disabilities Professional (QIDP) will obtain written informal consent from Client C's guardian for his restrictive programs. The QIDP will turn in the guardiansigned consent to the Residential Director for review for additional administrative oversight to ensure the Guardian written informal consent was obtained.</p>	03/16/2016			

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	<p>the above attempts have been made to assist [client C] in calming and redirecting his behavior have been unsuccessful staff will assist [client C] to his bedroom using approved CPI (Crisis Prevention Intervention-physical restraint techniques) 2 man assist." 3. "[Client C] at times seeks the pressure given by the weighted blanket to relax when he is agitated. During these times [client C] will be laying face up on his beanbag. The weighted blanket will be placed over [client C] to cover his arms and hands. There are times when the weighted blanket or bean bag alone are not enough pressure for [client C] to be able to calm down. During these times staff will place the weighted blanket on [client C] while he is laying face up on the large beanbag and then place the beanbag over [client C]." Client C's BSP indicated client C received the following medications: Depakote ER (Extended Release) 250 milligrams every day, Depakote ER 500 milligrams two times a day, Geodon 20 and 60 milligrams two times a day, Abilify 20 milligrams daily and Diazepam 2 milligrams three times a day and Paroxetine HCL 30 milligrams daily for mood and/or behaviors. Client C's May 2015 BSP indicated client C's mother was the client's guardian. Client C's record and/or BSP did not indicate the facility obtained written informed</p>			

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W 0318 Bldg. 00	<p>consent from client C's guardian for the client's restrictive program.</p> <p>Interview with the Director of Residential Services (DRS) and Administrative staff #1 was conducted on 1/21/16 at 3:04pm. When asked if the facility obtained WIC for client C's restrictions, the DRS stated "I'll have to check". The facility did not provide any additional documentation for review.</p> <p>9-3-4(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (B, C and D). The facility's Health Care Services failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility.</p> <p>Findings include:</p> <p>1. The facility's health care services failed to ensure its nursing services met the health care needs of clients. The facility's health care services failed to ensure its nursing services assessed</p>	W 0318	<p><b>W318</b> <b>Finding(s):</b> <b>1. "Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (B, C, and D). The facility's Health Care Services failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility."</b></p> <p><b>-</b> <b>Corrective Action(s):</b> <b>The facility's health care services to ensure its nursing services meet the healthcare and nursing needs</b></p>	03/16/2016	

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W 0331	<p>clients after a hospitalization, and transcribed medications correctly on a Medication Administration Record to prevent a significant medication error in regard to a client's seizure medication. The facility's health care services failed to develop risk plans, update risk plans, inform doctors of all medication errors, and to ensure clients' seizure medication levels were being periodically monitored to ensure the clients' optimum health. Please see W331.</p> <p>2. The facility's health care services failed to ensure its nursing services ensured client D's seizure medications were administered as ordered by the client's doctor. Please see W368.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p>		<p><b>of each client.</b></p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regard to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>2. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client.</p> <p>3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders.</p> <p>4. All staff located in the home will be trained on all changes made in regards to the client's health and nursing services when changes occur. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p>		

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Bldg. 00	<p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 3 of 4 sampled clients (B, C and D), the facility's nursing services failed to meet the nursing needs of clients in regard to transcribing medications correctly on a Medication Administration Record to prevent a significant medication error in regard to a client's seizure medication. The facility's nursing services failed to develop risk plans, update risk plans, inform doctors of all medication errors, to assess a client after being hospitalized, and to ensure clients' seizure medication levels were being periodically monitored to ensure the clients' optimum health.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-1/4/16 "[Client D] was discharged from the hospital on 12/24/2015. His MAR (Medication Administration Record) had previously had doctors orders for Phenobarb (Phenobarbital-seizures)</p>	W 0331	<p><b>W331</b> <b>Finding(s):</b> <b>1. "Based on interview and record review for 3 of 4 sampled clients (B, C, and D), the facility's nursing services failed to meet the nursing needs of clients in regard to transcribing medications correctly on a Medication Administration Record to prevent a significant medication error in regard to a client's seizure medication."</b></p> <p><b>Corrective Action(s):</b> <b>To ensure the facility's nursing services meet the nursing needs of the clients in regard to transcribing medications according to correctly on a Medication Administration Record to prevent a significant medication error in regard to a client's seizure medication.</b></p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regard to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>2. The Residential Nurse will give the Residential Director a report every time there is a doctor</p>	03/16/2016			

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	64.8mg (milligrams) tab (tablet), take 2 tablets by mouth every night at bedtime on it. Upon discharge from the hospital on 12/24/2015 the doctor's discharge orders were 32.4mg tab take 129.6mg oral at bedtime. The Residential Nurse altered the MAR at the group home, to match the current doctor orders, she transcribed the order incorrectly on 12/24/2015 and wrote Phenobarb 129.6mg (64.8 mg) take 4 tablets by mouth every night at bedtime. [Client D] received a double dose of his Phenobarbital from 12/24/2015 to 1/2/2016. The Residential House Manager found the error on 1/4/2016, [client D] was taken to the ER (emergency room), labs were drawn, his doctor was notified, he was discharged and sent back to the group home. [Client D] had a follow up appointment with his GP (General Practice) doctor today. His Phenobarbital level from the labs taken yesterday were within normal limits. Doctor is holding the Phenobarbital until Thursday as a precaution and ordered a repeat lab draw on Monday, 1/11/2016. The Residential Nurse making the error was immediately suspended and an investigation was started. Plan to Resolve [Client D] will continue to be monitored for any adverse affect of receiving too much Phenobarbital...."		ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of the client. 3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders. 4. All staff located in the home will be trained on all medication changes ordered by a physician when they occur. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.  <b>Finding(s)</b> 1. <b><i>"The facility's nursing services failed to develop risk plans, update risk plans, inform doctors of all medication errors, to assess a client after being brought home after being hospitalized, and to ensure clients seizure medication levels were being periodically monitored to ensure the clients' optimum health."</i></b> <b>Corrective Action(s):</b> <b>The facility's nursing staff will develop risk plans, update risk plans, inform doctors of any</b>		

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	<p>The facility's 1/12/16 Residential Services Investigation Checklist indicated the facility conducted an investigation in regard to client D's significant medication error. The facility's 1/12/16 investigation indicated the nurse who made the error was an RN (Registered Nurse). The facility's investigation indicated facility staff, who worked in the group home, were told to administer 4 tablets of client D's Phenobarbital by the nurse and/or other staff as instructed. The facility's investigation indicated "...12/11/15 The Phenobarb was stopped by the doctor due to [client D] being lethargic. He was taken to the hospital on 12-13-15, and was found to be septic. On 1/1/16 Carvedilol was stopped per doctors (sic) orders because [client D's] blood pressure was so low. On 1/1/16 it was noted that [client D] had received 4 64.8mg tabs of Phenobarb on both 1/1 and 1/2...On January 4th, it was brought to the attention of the Director of Residential Services that person served [client D] had been receiving a double dose of his medication Phenobarbital for ten days. [RN #1], the nurse that transcribed the wrong dosage...When [client D] was released from the hospital the doctor had prescribed him to take 4 tabs at 32.4mg per pill at bed time every night.</p>		<p><b>medication errors, assess all persons served after all hospitalizations, and ensure medication levels are being periodically monitored to ensure all persons served optimum health, the following corrective actions are being implemented.</b></p> <p>1. As part of the Periodic Service Review process, the Assistant Residential Director will review all nursing notes and person served plans to ensure it is accurate and updated information.</p>	

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	<p>However, [client D] was already on the medication, so the pharmacy just continued with the same pills. The pills he was already on of the medication had 64.8mg per pill. The house manager stated that his Phenobarbitol (sic) had always been 64.8mg per tab. During the investigation, the house manager stated that [RN #1] had changed the Narcotic count record to say that staff were to administer 4 tabs of the Phenobarbitol (sic) instead of the 2 tabs that were prescribed. The house manager stated that she believed [RN #1] instructed the staff to administer 4 of the pills because she was going with what the hospital wrote the prescription for. The house manager stated that [RN #1] checked in the medications when they received them from the pharmacy, but she did not catch the error then. The house manager stated that she found the error when she went to the home and looked through all of the paperwork after another staff member had called her and told her that she felt like [client D's] medications needed to be looked at. The Team Lead from the house stated that she was passing meds on January 2nd (second), when she thought there was an issue. She stated that she gave [client D] two of the pills at first, but then ended up giving him a total of 4 of the pills because on the MAR it stated to administer 4 pill (sic). She</p>			

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	<p>stated that all of the staff before her had also given him 4 pills at every 8pm med (medication) time per the MAR. She stated that she still felt that it wasn't right, so she contacted the nurse. She stated that the nurse then told her to go with what the pharmacy sent as the dose...[RN #1], the nurse, stated that she instructed the staff to administer 4 pills per dose because the instructions from the hospital stated to administer 4 pills at 32.4mg were to be administered to amount to 129.6. She stated that the pharmacy gave them the other amount of medication in the pills. She stated that she first realized the error on Sunday when she went over to the home to assess [client D] due to him having low blood pressure. She stated that she got the pills out and then got her phone out and compared the pills to one another. She stated that she got the stickers out from the prescription and thought that the staff was administering the medication wrong. She stated that she then called the doctor to inform him of the situation. She stated the doctor informed her to hold the 8pm dose for the day, and then to take [client D] to get his labs done on Monday. She stated that she was the one that had transcribed the instructions for the staff to follow starting on December 24th to January 2nd. She stated that she had noticed signs that it may have been affecting him because he</p>			

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	<p>was lethargic and not himself on Sunday....Due to the medication error being significant, and lasting for ten days it is being recommended that the nurse from the group home be terminated...Also, all of the staff from the group home will be retrained on medication administration."</p> <p>Staff #1's 1/4/16 Investigation Interview Form also indicated client D was not given the correct dose of his Metronidazole (antibiotic) which was to be 500 mg two times a day but client D had only received Metronidazole 250 mg two times a day.</p> <p>RN #1's 1/5/16 Investigative Interview Form indicated she knew he was to receive the 32.4 mg tablets of Phenobarbital versus the 64.8 mg tablets. RN #1's statement indicated she was the one who had transcribed the order onto the MAR. RN #1's statement indicated "...The pharmacy gave us the other amount of medication...." RN #1's statement indicated she was the one who had realized the error on Sunday when she went to the group home to assess client D. RN #1's statement indicated she called the doctor once she realized staff had been giving the wrong medication.</p> <p>The facility's 1/12/16 investigation</p>			

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	<p>indicated the facility attached client D's hospital records from his 12/13/15 hospitalization. Client D's 12/24/15 Patient Instructions for: Client D indicated "Discharge Diagnosis: Community acquired pneumonia (J18.9)." Client D's discharge summary indicated the client was discharged on a pureed diet with thickened liquids. The discharge summary indicated client D was treated for "...Left sided Pneumonia...Septic Shock...Seizure Disorder...." Client D's 12/24/15 discharge summary indicated client D was to receive the following medications (not all inclusive): "...Metronidazole 250 mg tab 500 mg PO (by mouth) twice a day twice a day Phenobarbital 32.4 mg tab 129.6 oral at bedtime...." The facility's nurse failed to obtain clarification on the order if needed.</p> <p>An attached typed Medication Change note indicated "[Client D's] phenobarbital has been increased to 129.6 mg at 8 pm (sic) He is to receive 4 tablets at 8pm starting 12/24/2015. Please observe for over sedation (excessive drowsiness, difficulty with coordination, slurred speech) and report to the Residential Nurse on duty immediately." The medication change note neglected to specifically indicate the pill dosage of the</p>			

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	<p>4 tablets the client was to receive as the note implied client D was to receive 4 tablets of 129.6 mg tablets.</p> <p>An attached client D's December 2015 MAR indicated under the medication sections: "Phenobarb 129.6 mg Take 4 tablets by mouth every night at bedtime (4 tabs)...*Give 4 tablets* each tablet 32.4 use 4 tabs to equal 129.6 mg" was written where staff sign their initials. The facility's investigation indicated the facility neglected to include documentation from the pharmacy on what Phenobarbital dosage was sent to the group home. Client D's December 2015 MAR indicated client D received Metronidazole 250 mg 1 tablet twice a day (half the dose of what was ordered) for 10 days.</p> <p>An attached 12/24/15 Record Of Training Session, by RN #1, indicated "Title of Session: [Client D's] Medication Change Subject: phenobarbital 32.4 mg tablets-Increased Dose to 129.6 mg." The facility's nurse failed to obtain clarification on the Phenobarbital order from the hospital, failed to ensure client D's medications were transcribed onto the MAR correctly, and failed to monitor medications coming from the pharmacy to ensure correct dosing/medication was</p>			

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	<p>received to prevent errors.</p> <p>Client D's record was reviewed on 1/20/16 at 12:48 PM. Client D's Nurse's Notes indicated the following (not all inclusive):</p> <p>-1/1/16 "Staff called around 9 AM to report that [client D's] B/P (blood pressure) was low 88/65. Writer (LPN #1) called [name of doctor] to report. [Name of doctor] stated it could be due to the Carvedilol (hypertension-beta blocker) that was prescribed to him while he was in the hospital. [Name of doctor] asked that I go assess [client D]. Upon assessment B/P was 90/62, P (pulse): 60, R (respiration): 18, T (temperature): 94.0 temporal. [Client D] felt very cold to the touch. [Client D] was fairly lethargic. [Name of doctor] was called back and vitals were reported. [Name of doctor] stated he wanted the Carvedilol stopped and wanted [client D] monitored closely tonight and stated if his B/P dropped lower than 80/60 to take him to the ER (emergency room)...."</p> <p>-1/3/16 "Staff reported [client D] continues to be lethargic and vitals are 86/68, 84, 16 and 97.5 F (Fahrenheit). [Client D] can squeeze my hands equally in strength but he is weaker than his usual grips. He is appropriately answering</p>				

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	<p>yes/no questions. He is holding his head erect and appears somewhat sleepy.</p> <p>Upon review of records, it appears [client D] has received 4 64.8 mg tablets of phenobarbital on both January 1st (first) and January 2nd, @ (at) 8 pm. Called [name of doctor] to request directive. Awaiting return call." The entry was written by RN #1.</p> <p>-1/3/16 "[Name of doctor] returned call. Informed him of vitals and current level of function. Also informed him of [client D] receiving (4) 64.8 mg tablets instead of (2) 64.8 mg tablets on January 1st and January 2nd. [Name of doctor] stated to HOLD 8 pm phenobarbitol (sic) tonight. Also obtain phenobarbitol (sic) blood level Monday January 4, 2016. Once phenobarbitol (sic) blood level is obtained [name of doctor] will decide if staff are to hold Monday dose or administer the med. Staff have been directed to document ounces of fluid consumed every 2 hours and to obtain vitals every 2 hours. Will continue to observe."</p> <p>-1/4/16 Facility staff took client D to get the Phenobarbital lab. The note indicated staff was concerned about client D's "level of consciousness that he may need to be seen in the ER. [Client D] was taken to the ER around 230pm...." The</p>			

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	<p>note indicated the ER doctor checked client D and indicated it would take 24 hours for the client's Phenobarbital level to come back. The note indicated client D was sent home with instructions to monitor client D, and to hold the client's 8 PM Phenobarbital dose.</p> <p>-1/5/16 "[Name of doctor] gave a verbal order to hold phenobarbital until Thursday evening...Writer (LPN #1) put a hold on phenobarbital until Thursday (1/7/16)."</p> <p>-1/9/16 "Writer (LPN #1) was notified at 7:30am that [client D] had been taken to the ER for a series of cluster seizures that lasted for about 30 mins (minutes). Upon arrival at [name of hospital] ER...[name of doctor] came in and asked what had happened, [staff #2] explained what happened. Writer informed [name of doctor] that [name of doctor] had put a hold on the phenobarbital (sic) until Thursday (1-7-16) @ 8 pm when was to be resumed. [Staff #2] spoke up and stated it had not been resumed on Thursday (1-7-16). Upon looking at the MAR it appears that staff continued to hold med through Friday (1-8-16). Writer told [name of doctor] she was unclear as to why medication was not passed...." The note indicated client D was given an intravenous Phenobarbital</p>			

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	<p>and then sent back to the group home. The facility's nurse failed to ensure client D received his medication as ordered.</p> <p>-1/9/16 (6:00 PM) The facility's nurse was called by staff as client D had "...been seizing for about 10 min. I (LPN #1) told [staff #2] I was on my way. [Staff #2] asked if it was ok to administer Diastat (rectal medication for seizures). Writer told her to follow protocol and Dr. (doctor) orders. [Staff #2] stated his Dr. orders stated to administer after 10 minutes of seizure activity. [Staff #2] administered rectal Diastat at 6:12 pm. When writer arrived [client D] was awake but not alert. [Client D] had several small tremors and [staff #2] swiped VNS (Vagal Nerve Stimulator) everytime, each time VNS was swiped [client D] stopped seizing...."</p> <p>-1/11/16 "late entry for 1/5/16 [Client D] was taken to [name of doctor] for a follow up from his hospital stay. [Name of doctor] gave us results of phenobarbital level -60- was the level... [Name of doctor] gave an order to hold pheno (phenobarbital) until Jan (January) 7th due to being toxic to his phenobarbital...." Client D's nursing notes indicated the facility's nurse failed to document and/or inform client D's doctors of the medication errors prior to</p>			

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	<p>January 1 and January 2, 2016 (12/24/15 to 12/31/15).</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04 PM indicated client D had a seizure diagnosis. Administrative staff #1 and the DRS indicated there had been 2 medication errors in regard to the client's Phenobarbital. LPN #1 indicated she did not know why the staff did not restart client D's Phenobarbital on 1/7/16 as ordered. LPN #1 stated "I told them what to do but staff did not follow."</p> <p>Administrative staff #1 and the DRS indicated RN #1 was terminated due to the 12/24/15 to 1/2/16 medication error with client D's double dosing of the Phenobarbital on 1/10/16. LPN #1, administrative staff #1 and the DRS stated client D had been in the hospital and was discharged on 12/24/15 for Pneumonia and "Phenobarbital toxicity." The DRS indicated RN #1 transcribed the order on the MAR wrong and facility staff #1 caught the error on 1/4/16. LPN #1, administrative staff #1 and the DRS indicated facility staff had been trained in regard to medication administration. LPN #1 indicated she had trained staff on administering client D's medication changes and orders. LPN #1 indicated she would look for the documented</p>			

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	<p>training, but did not provide any additional training documentation. Administrative staff #1 and the DRS stated "She (nurse) will have to be monitored and expectations made with staff."</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 1/19/16 at 12:50 PM. Client D's 10/23/15 reportable incident report indicated on 10/22/15, "At approximately 12:30pm [client D] began having a cluster of seizures for the second time. Diastat was administered but was not effective and [client D] continued to have seizures. Staff (per [client D's] Seizure Risk Plan) called an ambulance and [client D] was transported to [name of hospital]. While in transport to the hospital [client D] was administered 20 mg of Valium (seizures) from the Paramedics but continued to have seizures...." The reportable incident report indicated labs and a chest Xray were performed in the ER. The reportable incident report indicated client D was released and the facility;s nurse transported the client home. The 10/22/15 reportable incident report indicated "...With less than 2 blocks traveled [client D] began to have a grand mal seizure. Residential Nurse pulled to the side of the road to ensure [client D]</p>				

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	<p>was in a safe position to attempt to prevent injury from the seizure he was having. Residential Nurse called the ER and notified them that she was returning with [client D] having a grand mal seizure. ER nurse and the paramedics met [client D] at the door and transported him back into the ER. [Client D] was administered 10 mg of Valium through an IV (intravenous) from the ER doctor but continued to have seizures. The ER doctor then administered a 15 minute dose of Keppra (seizure) through the IV. This was successful in stopping the grand mal seizure. The ER doctor observed [client D] and found that his body was relaxed due to the medication but there was still some seizure activity as [client D's] cheeks were twitching. The ER doctor administered 10 mg of versed (seizure) which was successful in stopping all seizure activity. [Client D] was admitted to ICU (Intensive Care Unit) for observation. There was no more seizure activity. The lab work revealed that [client D] was low on potassium. ICU nurse administered potassium to [client D] and stated that one dosage should return his potassium to a normal level. [Client D] was released from the hospital to return home on 10/23/15 with no medication changes...Staff will continue to follow [client D's] Seizure Risk Plan as well as</p>			

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	<p>all risk plans...."</p> <p>The facility's 10/30/15 follow up report to the 10/23/15 reportable incident report indicated "...[Client D] was seen by his Neurologist, [name of doctor], for an evaluation. [Name of doctor] determined that [client D] had the seizures due to flu like symptoms. There no are changes at this point and time...." The facility's follow-up report indicated client D was to return to the doctor in 6 months unless he had seizures, and then the client was to return to see the neurologist at that time.</p> <p>Client D's record was reviewed on 1/20/16 at 12:48 PM. Client D's 10/27/15 physician's orders indicated client D's diagnosis included, but was not limited to, Seizure Disorder.</p> <p>Client D's hospital records, Discharge Instructions, Transition of Care Plans and Patient Plans indicated the following (not all inclusive):</p> <p>-2/20/15 Client D's Transition of Care Record indicated client D's Primary diagnosis was "1) Seizure Disorder 2) Acute hypokalemia (low potassium)."</p> <p>Client D's 2/20/15 Discharge Instructions indicated client D was seen in the ER due to seizures. Client D's discharge instructions indicated client D should eat</p>			
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	<p>foods like honey dew melons, potatoes, peaches, orange juice, tomato juice and meats to increase his potassium level.</p> <p>-10/22/15 Client D's Discharge Instructions indicated client D's diagnoses included, but were not limited to, "Seizure disorder (sic) Intractable" and "Status epilepticus (sic)."</p> <p>-12/24/15 Client D's Discharge Instructions indicated client D was admitted to the hospital on 12/13/15 for "Left sided Pneumonia," Septic Shock and Seizure Disorder. Client D's discharge instructions indicated the client was placed on a pureed diet with thickened liquids. Client D's 12/24/15 Patient Plan indicated client D had "Phenobarbital Toxicity (dangerous high levels)" as well.</p> <p>-1/4/16 Transition of Care Record indicated client D was seen in the ER due to an "Altered Mental Status." The care plan indicated client D had a "...Primary Diagnosis 1) Decreased level of consciousness 2) Free text Dx (diagnosis): phenobarbital (sic) overmedication Chief Complaint 1) Drug toxicity/reaction to phenobarbital 2) Drug toxicity/complication...."</p> <p>-1/9/16 Client D was seen in the ER due</p>			

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	<p>to seizures.</p> <p>Client D's Physician Statements, Patient Plans and notes indicated the following (not all inclusive):</p> <p>-4/1/15 Client D saw his Neurologist for "increased seizure activity-med changes." The Neurologist did not make any changes at that time.</p> <p>-6/10/15 Client D saw the Neurologist for a VNS check. The 6/10/15 report did not indicate any changes in client D's medications. The 6/10/15 report/statement indicated "...stable last 2 1/2 mo (months)...."</p> <p>-10/8/15 Client D saw a nurse practitioner due to client D demonstrating "lethargy-difficulty walking." The note indicated labs and Phenobarbital and Valium (seizure) levels were ordered. The note indicated "observe for fall-due to being high fall risk."</p> <p>-10/28/15 Client D saw his Neurologist. The note indicated no changes were made in regard to client D's seizure medications.</p> <p>-12/11/15 Hand written note written by RN #1 indicated "[Client D] has been lethargic the past 3-4 days. Labs were</p>			

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	<p>drawn 12/9 and phenobarb level is &gt; (greater than) 80 meq/ml (milliequivalents/millimeters). Lamictal (seizure) level is pending. Please review and advise on how to proceed with [client D's] medication regimen." The bottom of the note indicated client D's Neurologist replied "Stop phenobarb check on Monday."</p> <p>-1/5/16 Client D saw his primary care doctor for follow up due to the client's hospitalization for pneumonia. The note indicated "Pt (patient) with Phenobarbital Toxicity seen in ER yesterday. Doing well with Pneumonia (after) Hospitalization...Watch for increased sedation. Speech eval (evaluation) for swallowing." An attached 1/4/16 lab page indicated client D's Phenobarbital was "64.4 H" (high-normal range 15.0 to 40.0). The 1/4/16 lab report indicated Phenobarbital was considered "toxic" when the level was greater than 50.0. The lab report indicated client D's last dose of the Phenobarbital was on "1-2-16 @ 2000 (8 PM)." The lab report indicated client D's Phenobarbital level was a "critical laboratory result" and it indicated "CALL RESULTS STAT (right away) TO [NAME OF DOCTOR]."</p> <p>-1/5/16 Client D's Patient Plan indicated the client was seen by his primary</p>			

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	<p>physician for "Phenobarbital Toxicity, Pneumonia." The report indicated the "Assessment/Plan Phenobarbital toxicity, accidental or unintentional,...Epilepsy, unsp (unspecified), not retractable, without status ep (epilepticus), Bacterial pneumonia Patient in is in the office for Transition of Care Visit...Repeat chest x-ray. His phenobarbital level was elevated yesterday raised and receiving double doses for at least a few days before this. We'll go back to the dose he is supposed to have of 64.2 mg 2 tablets daily and recheck a phenobarbital level on next Monday..." The Plan of Care indicated client D had been in the hospital for "septic with pneumonia" and Phenobarbital toxicity when discharged on 12/24/15.</p> <p>-1/13/16 Client D saw the nurse practitioner for a follow-up from the client's ER visit on 1/4/16. Phenobarbital level was ordered for 1/15/16 as client D was to see the Neurologist on 1/19/16. The form indicated "Continue seizure monitoring."</p> <p>-1/20/16 Client D's Keppra (seizure) medication was increased and the client's Phenobarbital was decreased by the Neurologist. An attached 1/20/16 physician's order indicated "phenobarb 32.4 mg (2 tablets) &amp; 1/2 po (by mouth)</p>			

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	<p>q (every) d (day) x 2 wks (weeks) then (2 tablets) po q HS (bed time) x 2 wks."</p> <p>An attached 1/20/16 note entitled Medication Change for Phenobarbital and Keppra indicated "[Client D] was seen by [name of Neurologist] today for a routine Neurology checkup. [Name of doctor] would like to taper [client D] off of his Phenobarbital and increase his Keppra dose." The typed note included documented side effects for Phenobarbital and Keppra medications. The note indicated "...If you notice any of these side effects or any other abnormal issues with [client D] after starting these medication changes or if you have any questions about this training or about any of [client D's] medications please notify the on call nurse and RHM (Residential Home Manager) [staff #1]."</p> <p>Client D's Nurse's Notes indicated the following (not all inclusive):</p> <p>-2/6/15 "This writer/RN (RN #2) received a phone call from DSP (Direct Support Professional) at group home stating [client D] had a 2 minute seizure. No injuries. Staff was directed to follow seizure risk plan. Staff then called again stating [client D] had experienced 2 more seizures. Staff administered Diastat rectally. [Client D] then experienced</p>			

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	<p>another seizure. 911 was called...."</p> <p>-2/20/15 "Rec'd (received) call from workshop [client D] had 3 seizures, his VNS/magnet combination did not stop the seizures and workshop nurse stated he was administered rectal diastat &amp; EMS (emergency medical service) called, per risk plan. [Client D] was transported via ambulance to [name of hospital]. He has been observed and is scheduled for d/c (discharge) as soon as lab results are known...."</p> <p>-3/4/15 "[Client D] experienced 3 seizures which did not respond to his VNS/magnet and staff administered rectal diastat. He had another seizure and per protocol staff called 911. He was transported to [name of hospital] ER for evaluation/treatment. While there his electrolytes were out of normal range (sodium 149 (normal 135-145)...." The note indicated client D was admitted to the hospital.</p> <p>-3/24/15 "Staff reported on 3/22/15 [client D] was admitted to the hospital due to seizure activity. He spent Sunday night at the hospital and was discharged Monday evenings with no restrictions...." The note indicated the client's seizure medications were increased.</p>				

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	<p>-3/26/15 "Received a phone call from the workshop that [client D] had multiple seizures and was being transported to ER for evaluation...."</p> <p>-3/31/15 "[Client D] was seen today by [name of doctor] to follow up from his ER visit on 3/26 and hospital stay on 3/24, along with medication changes that took effect on 3/28/15. Residential group home staff had reported changes in [client D's] baseline behavior as well as an unsteady gait. [Name of doctor] wants to keep the Keppra dose the same, but decrease the Klonopin dose...."</p> <p>-4/8/15 Client D saw his Neurologist. The note indicated the nurse asked for the client's Diastat dose be increased due to client D's seizures. The note indicated the Neurologist did not want to increase the dose.</p> <p>-10/22/15 "Rec'd call at approximately 7:30 AM. [Client D] was having seizure activity. Staff indicated he required Diastat and it was effective...."</p> <p>-10/22/15 "Was at group home doing other tasks when staff called writer (RN #1) to the living room area where [client D] was having another seizure. Followed all seizure plans, Diastat was ineffective and 911 was called. He was transported</p>			

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	<p>to [name of hospital] where he was for intractable (seizures that fail to come under control with treatment) seizures. He was released to this writer and while being transported home, he began to have another grand mal seizure in the car with this writer. Writer secured safety and turned around. Called [name of hospital] and explained recurrent seizures. EMT/Paramedic met writer at ER doors and [name of hospital] staff removed [client D] from writer's car and transported him via gurney to ER for evaluation and treatment. He was given IV anti seizure meds and eventually he was admitted to [name of hospital] ICU for observation."</p> <p>-10/28/15 Client D saw his Neurologist due to his recent seizure activity. The note indicated "...[Name of Neurologist] determined the seizures may have been due to [client D] having flu-like symptoms..."</p> <p>-12/8/15 "[Client D] was seen by [name of CNP] (Certified Nurse Practitioner) for recent fall, lethargy and poor balance. No med changes, Negative evaluation. Labs ordered..."</p> <p>-12/11/15 "[Client D] is very lethargic and unsteady on his feet. He is having difficulty forming words and keeping eye</p>			

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	<p>contact. He does recognize staff and responds with yes/no answers. Called [name of doctor's] office and to alert them of [client D's] lethargy...will find out the lab results then she will call back with information and any orders needed...."</p> <p>-12/11/15 "Labs abnormal = Phenobarbitol (sic) &gt; 80 mcq/ml (normal range 15-40 mcq/ml). Contacted neurologist [name of doctor] regarding phenobarbitol (sic). Orders rec'd to STOP phenobarbitol NOW and recheck level Monday 12/14/15...."</p> <p>-12/13/15 "Staff informed writer (RN #1) [client D's] more lethargic (sic) B/P (blood pressure) this morning was 106/62. Instructed staff to repeat B/P every 2 hrs (hours) and report any abnormal B/P to writer. In the mid afternoon (approximately 1:30pm) staff reported B/P 79/49 and this writer contacted RHM [staff #1] and arrangements were made to take [client D] to ER for evaluation...Upon evaluation he was determined to have left lung pneumonia and septic. He was admitted to ICU."</p> <p>-12/14/15 Client D remained in the hospital"...Non-responsive to staff, but moans in response to movement of his</p>			

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	<p>limbs by writer (RN #1)."</p> <p>-12/18/15 "[Client D] is awake and alert. He remains in the hospital but has been moved to a medical bed...."</p> <p>-12/21/15 "Spoke with nurse at [name of hospital] regarding [client D]. She stated he no longer has IV fluids, no catheter, no supplemental oxygen. His vitals signs are stable. Therapy is working with him for strengthening...."</p> <p>-1/1/16 "Staff called around 9 AM to report that [client D's] B/P (blood pressure) was low 88/65. Writer (LPN #1) called [name of doctor] to report. [Name of doctor] stated it could be due to the Carvedilol (hypertension-beta blocker) that was prescribed to him while he was in the hospital. [Name of doctor] asked that I go assess [client D]. Upon assessment B/P was 90/62, P (pulse): 60, R (respiration): 18, T (temperature): 94.0 temporal. [Client D] felt very cold to the touch. [Client D] was fairly lethargic. [Name of doctor] was called back and vitals were reported. [Name of doctor] stated he wanted the Carvedilol stopped and wanted [client D] monitored closely tonight and stated if his B/P dropped lower than 80/60 to take him to the ER (emergency room). Staff was instructed to check B/P and Pulse every 2 hours.</p>				

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	<p>Medication was stopped on the MAR and medication was pulled from the medication cabinet."</p> <p>-1/3/16 "Staff reported [client D] continues to be lethargic and vitals are 86/68, 84, 16 and 97. 5 F (Fahrenheit). [Client D] can squeeze my hands equally in strength but he is weaker than his usual grips. He is appropriately answering yes/no questions. He is holding his head erect and appears somewhat sleepy. Upon review of records, it appears [client D] has received 4 64.8 mg tablets of phenobarbital on both January 1st (first) and January 2nd, @ (at) 8 pm. Called [name of doctor] to request directive. Awaiting return call." The entry was written by RN #1.</p> <p>-1/3/16 "[Name of doctor] returned call. Informed him of vitals and current level of function. Also informed him of [client D] receiving (4) 64.8 mg tablets instead of (2) 64.8 mg tablets on January 1st and January 2nd. [Name of doctor] stated to HOLD 8 pm phenobarbital (sic) tonight. Also obtain phenobarbital (sic) blood level Monday January 4, 2016. Once phenobarbital (sic) blood level is obtained [name of doctor] will decide if staff are to hold Monday dose or administer the med. Staff have been directed to document ounces of fluid</p>			

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	<p>consumed every 2 hours and to obtain vitals every 2 hours. Will continue to observe."</p> <p>-1/4/16 Facility staff took client D to get the Phenobarbital lab. The note indicated staff was concerned about client D's "level of consciousness that he may need to be seen in the ER. [Client D] was taken to the ER around 230pm...." The note indicated the ER doctor checked client D and indicated it would take 24 hours for the client's Phenobarbital level to come back. The note indicated client D was sent was sent home with instructions to monitor client D, and to hold the client's 8 PM Phenobarbital dose.</p> <p>-1/5/16 "[Name of doctor] gave a verbal order to hold phenobarbital until Thursday evening...Writer (LPN #1) put a hold on phenobarbital until Thursday (1/7/16)."</p> <p>-1/9/16 "Writer (LPN #1) was notified at 7:30am that [client D] had been taken to the ER for a series of cluster seizures that lasted for about 30 mins (minutes). Upon arrival at [name of hospital] ER...[name of doctor] came in and asked what had happened, [staff #2] explained what happened. Writer informed [name of doctor] that [name of doctor] had put a</p>			

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	<p>hold on the phenobarbitol (sic) until Thursday (1-7-16) @ 8 pm when was to be resumed. [Staff #2] spoke up and stated it had not been resumed on Thursday (1-7-16). Upon looking at the MAR it appears that staff continued to hold med through Friday (1-8-16). Writer told [name of doctor] she was unclear as to why medication was not passed...." The note indicated client D was given an intravenous Phenobarbital and then sent back to the group home.</p> <p>-1/9/16 (6:00 PM) The facility's nurse was called by staff as client D had "...been seizing for about 10 min. I (LPN #1) told [staff #2] I was on my way. [Staff #2] asked if it was ok to administer Diastat (rectal medication for seizures). Writer told her to follow protocol and Dr. (doctor) orders. [Staff #2] stated his Dr. orders stated to administer after 10 minutes of seizure activity. [Staff #2] administered rectal Diastat at 6:12 pm. When writer arrived [client D] was awake but not alert. [Client D] had several small tremors and [staff #2] swiped VNS (Vagal Nerve Stimulator) everytime, each time VNS was swiped [client D] stopped seizing...." The note indicated the nurse attempted to call client D's doctor 3 times with no response/return call from the doctor.</p>			

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	<p>-1/11/16 "late entry for 1/5/16 [Client D] was taken to [name of doctor] for a follow up from his hospital stay. [Name of doctor] gave us results of phenobarbital level -60- was the level... [Name of doctor] gave an order to hold pheno (Phenobarbital) until Jan (January) 7th due to being toxic to his phenobarbital..."</p> <p>-1/13/16 Client D saw the nurse practitioner. The note indicated client D's Phenobarbital level was "...49 right now...." The note indicated the lab was to be repeated on 1/15/16.</p> <p>-undated entry "At 2:30 pm writer (staff #1) received a phone call from [name of nurse at doctor's office]. [Name of nurse] stated that [client D's] lab results came in from A.M. draw his phenobarbital level was up to 50.9. Nurse instructed writer to decrease from 129.6 mg of phenobarbital @ 8 pm to 32.4 mg x (times) 3 @ 8 pm totaling 97.2 mg. Medication was called into [name of pharmacy] by [LPN #1]. 1st training done by house manager. Mars corrected by nurse. [Name of doctor's office nurse] also instructed writer to take labs again in two weeks."</p> <p>-1/20/16 "[Client D] was seen for a follow up from being hospitalized for pneumonia and seizure activity. the (sic)</p>						

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	<p>results of this appointment are as follows: 1) taper off of phenobarbital. [Client D] will take 2 1/2 tablets by mouth @ bedtime for two week starting 1-21-16 &amp; ending on 2-4-16 then he will take two tablets by mouth once a day at bedtime for 2 weeks start date will be 2-5-16 &amp; end date will be 2-19-16. 2) [Name of Neurologist] wants to increase his Keppra dose to 750 mg by mouth twice a day @ 8 am &amp; 8 pm. Start date will be 1-21-16...."</p> <p>Client D's record indicated the facility's nurse failed to ensure staff documented client D's seizure activities on a seizure record as client D did not have a seizure record for 2015 and 2016.</p> <p>Client D's 2/25/15 Individual Support Plan (ISP) and/or record indicated the client had a Seizure Risk Management Plan (RMP) dated 2/25/15. Client D's 2/25/15 ISP and/or RMP indicated the facility's nurse did not address and/or include status epilepticus seizures. Client D's ISP indicated the facility's nurse failed to address/include a risk plan for Hypokalemia and Phenobarbital Toxicity (prior to client D's doctor tapering off). The facility's nurse failed to assess client D after he was discharged from the hospital on 12/24/15 to ensure continuity of care, and to put additional nursing</p>			

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	<p>measures in place to monitor the client's toxic Phenobarbital level and/or health.</p> <p>Interview with staff #3 on 1/13/16 at 4:53 PM indicated client D was in the hospital due to seizures in December 2015. Staff #3 stated client D had "clusters" of seizures.</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04 PM indicated client D had a seizure diagnosis. LPN #1, administrative staff #1 and the DRS stated client D had been in the hospital and was discharged on 12/24/15 for Pneumonia and "Phenobarbital toxicity." The DRS stated a medication error was made in regard to client D's Phenobarbital where the client was "double dosed" after his hospital discharge from 12/24/15 to 1/2/16. The DRS indicated RN #1 transcribed the order on the MAR wrong and facility staff #1 caught the error on 1/4/16. DRS and LPN #1 indicated RN #1 did not assess client D after his hospital discharge on 12/24/15. LPN #1 and the DRS indicated client D should have been assessed by a nurse as the client was in the hospital due to "Sepsis Pneumonia and Phenobarbital Toxicity." When asked how often client D's potassium level was monitored, LPN #1 indicated</p>			

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	<p>she was not sure. When asked if client D had a risk plan for Hypokalemia, LPN #1 stated "No." LPN #1 indicated she was not aware the hospital had diagnosed client D with Hypokalemia. When asked if client D had a risk plan for Status Epilepticus, LPN #1 and the DRS indicated client D's seizure risk plan did not specifically include/address Status Epilepticus. LPN #1 and the DRS stated facility staff were to use client D's Diastat when the client had "three or more cluster of seizures and if don't work call 911." LPN #1 indicated client D also had a VNS which facility staff were to swipe with a magnet when the client had a seizure. When asked if client D's seizure plan had been updated, LPN #1 and the DRS indicated client D's risk plan had not been updated. LPN #1 and the DRS indicated client D's Neurologist recently decreased client D's Phenobarbital to take the client off the medication. LPN #1 indicated the Neurologist indicated client D could become toxic on the Phenobarbital again.</p> <p>3. Client B's record was reviewed on 1/20/16 at 12:37pm. Client B's 10/26/15 Physician's orders indicated client B was prescribed Divalproex also called Depakote (seizure medication) 500 milligrams ER tab twice daily for seizures and Divalproex 250mg at</p>			

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	<p>bedtime for seizures.</p> <p>Client B's 10/14/15 annual physical indicated "Depakote level by [name of mental health provider]."</p> <p>Client B's labs indicated the client's last Depakote level was completed on 8/23/12 and her levels were low at this time.</p> <p>Client C's record was reviewed on 1/20/16 at 1:26pm. Client C's 10/26/15 Physician's orders indicated client C was prescribed Divalproex also called Depakote (seizure medication) 500 milligrams ER tab twice daily.</p> <p>Client C's record did not indicate client C has had labs to check his Depakote levels in his blood.</p> <p>Interviews with the Director of Residential Services (DRS) and Administrative staff #1 was conducted on 1/21/16 at 3:04pm. When asked when client B and client C had their depakote levels last checked the DRS stated "I'll have to check". The facility was unable to provide any additional documentation for review.</p> <p>This federal tag relates to complaint #IN00185316.</p>			

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W 0368  Bldg. 00	<p>9-3-6(a)</p> <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. Based on interview and record review for 1 of 4 sampled clients (D), the facility failed to ensure a client's seizure medications were administered as ordered by the client's doctor.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations were reviewed on 1/19/16 at 12:50 PM. The facility's reportable incident reports, internal Accident/Incident Reports (IARs) and/or investigations indicated the following (not all inclusive):</p> <p>-1/4/16 "[Client D] was discharged from the hospital on 12/24/2015. His MAR (Medication Administration Record) had previously had doctors orders for Phenobarb (Phenobarbital-seizures) 64.8mg (milligrams) tab (tablet), take 2 tablets by mouth every night at bedtime on it. Upon discharge from the hospital on 12/24/2015 the doctor's discharge orders were 32.4mg tab take 129.6mg oral at bedtime. The Residential Nurse</p>			W 0368	<p><b>W368</b></p> <p><b>Finding(s):</b></p> <p><b>1. "Based on interview and record review for 1 of 4 sampled clients (D), the facility failed to ensure a client's seizure medications were administered as ordered by the client's doctor."</b></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure the facility administers clients' medications according to doctor orders to ensure health and safety of the client.</b></p> <p>1. The Residential Nurse and Residential House Manager will both be giving weekly report that will be documented, to the Residential Director, for client D in regard to his seizure activity, health, and any appointments that were attended for that week and any upcoming appointments for additional administrative oversight.</p> <p>2. The Residential Nurse will give the Residential Director a report every time there is a doctor ordered change to client D's seizure medication/medications for administrative oversight to ensure the health and safety of</p>		03/16/2016

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	<p>altered the MAR at the group home, to match the current doctor orders, she transcribed the order incorrectly on 12/24/2015 and wrote Phenobarb 129.6mg (64.8 mg) take 4 tablets by mouth every night at bedtime. [Client D] received a double dose of his Phenobarbital from 12/24/2015 to 1/2/2016. The Residential House Manager found the error on 1/4/2016, [client D] was taken to the ER (emergency room), labs were drawn, his doctor was notified, he was discharged and sent back to the group home. [Client D] had a follow up appointment with his GP (General Practice) doctor today. His Phenobarbital level from the labs taken yesterday were within normal limits. Doctor is holding the Phenobarbital until Thursday as a precaution and ordered a repeat lab draw on Monday, 1/11/2016. The Residential Nurse making the error was immediately suspended and an investigation was started. Plan to Resolve [Client D] will continue to be monitored for any adverse affect of receiving too much Phenobarbital...."</p> <p>The facility's 1/12/16 Residential Services Investigation Checklist indicated the facility conducted an investigation in regard to client D's significant medication error. The</p>		<p>the client.</p> <p>3. The Residential nurse will scan and email or fax the Medication Administration Record whenever there are changes made as per doctor orders to the Residential Director along with the doctor order to give administrative oversight to ensure medications are administered per doctor orders.</p> <p>4. All staff located in the home will be trained on all medication changes ordered by a physician when they occur. Record of Training forms will be completed following staff trainings and will be submitted to the Residential Director for administrative oversight.</p> <p>-</p>		

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	<p>facility's 1/12/16 investigation indicated the nurse who made the error was an RN (Registered Nurse). The facility's investigation indicated facility staff, who worked in the group home, were told to administer 4 tablets of client D's Phenobarbital by the nurse and/or other staff as instructed. The facility's investigation indicated "...12/11/15 The Phenobarb was stopped by the doctor due to [client D] being lethargic. He was taken to the hospital on 12-13-15, and was found to be septic...."</p> <p>Staff #1's 1/4/16 Investigation Interview Form indicated client D was not given the correct dose of his Metronidazole (antibiotic) which was to be 500 mg two times a day but client D had only received Metronidazole 250 mg two times a day.</p> <p>RN #1's 1/5/16 Investigative Interview Form indicated she knew he was to receive the 32.4 mg tablets of Phenobarbital versus the 64.8 mg tablets. RN #1's statement indicated she was the one who had transcribed the order onto the MAR. RN #1's statement indicated "...The pharmacy gave us the other amount of medication...." RN #1's statement indicated she was the one who had realized the error on Sunday when she went to the group home to assess</p>			

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	<p>client D. RN #1's statement indicated she called the doctor once she realized staff had been giving the wrong medication.</p> <p>The facility's 1/12/16 investigation indicated the facility attached client D's hospital records from his 12/13/15 hospitalization. Client D's 12/24/15 Patient Instructions for: [Client D] indicated "Discharge Diagnosis: Community acquired pneumonia (J18.9)." Client D's discharge summary indicated the client was discharged on a pureed diet with thickened liquids. The discharge summary indicated client D was treated for "...Left sided Pneumonia...Septic Shock...Seizure Disorder...." Client D's 12/24/15 discharge summary indicated client D was to receive the following medications (not all inclusive): "...Metronidazole 250 mg tab 500 mg PO (by mouth) twice a day twice a day Phenobarbital 32.4 mg tab 129.6 oral at bedtime...."</p> <p>An attached client D's December 2015 MAR indicated under the medication sections: "Phenobarb 129.6 mg Take 4 tablets by mouth every night at bedtime (4 tabs)...*Give 4 tablets* each tablet 32.4 use 4 tabs to equal 129.6 mg" was written where staff sign their initials.</p>			

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	<p>Client D's record was reviewed on 1/20/16 at 12:48 PM. Client D's Nurse's Notes indicated the following (not all inclusive):</p> <p>-1/3/16 "Staff reported [client D] continues to be lethargic and vitals are 86/68, 84, 16 and 97.5 F (Fahrenheit). [Client D] can squeeze my hands equally in strength but he is weaker than his usual grips. He is appropriately answering yes/no questions. He is holding his head erect and appears somewhat sleepy. Upon review of records, it appears [client D] has received 4 64.8 mg tablets of phenobarbital on both January 1st (first) and January 2nd, @ (at) 8 pm. Called [name of doctor] to request directive. Awaiting return call." The entry was written by RN #1.</p> <p>-1/3/16 "[Name of doctor] returned call. Informed him of vitals and current level of function. Also informed him of [client D] receiving (4) 64.8 mg tablets instead of (2) 64.8 mg tablets on January 1st and January 2nd. [Name of doctor] stated to HOLD 8 pm phenobarbitol (sic) tonight. Also obtain phenobarbitol (sic) blood level Monday January 4, 2016. Once phenobarbitol (sic) blood level is obtained [name of doctor] will decide if staff are to hold Monday dose or administer the med. Staff have been</p>			

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	<p>directed to document ounces of fluid consumed every 2 hours and to obtain vitals every 2 hours. Will continue to observe."</p> <p>-1/4/16 Facility staff took client D to get the Phenobarbital lab. The note indicated staff was concerned about client D's "level of consciousness that he may need to be seen in the ER. [Client D] was taken to the ER around 230pm..." The note indicated the ER doctor checked client D and indicated it would take 24 hours for the client's Phenobarbital level to come back. The note indicated client D was sent home with instructions to monitor client D, and to hold the client's 8 PM Phenobarbital dose.</p> <p>-1/5/16 "[Name of doctor] gave a verbal order to hold phenobarbital until Thursday evening...Writer (LPN #1) put a hold on phenobarbital until Thursday (1/7/16)."</p> <p>-1/9/16 "Writer (LPN #1) was notified at 7:30am that [client D] had been taken to the ER for a series of cluster seizures that lasted for about 30 mins (minutes). Upon arrival at [name of hospital] ER...[name of doctor] came in and asked what had happened, [staff #2] explained what happened. Writer informed [name of doctor] that [name of doctor] had put a</p>			

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	<p>hold on the phenobarbital (sic) until Thursday (1-7-16) @ 8 pm when was to be resumed. [Staff #2] spoke up and stated it had not been resumed on Thursday (1-7-16). Upon looking at the MAR it appears that staff continued to hold med through Friday (1-8-16). Writer told [name of doctor] she was unclear as to why medication was not passed...." The note indicated client D was given an intravenous Phenobarbital and then sent back to the group home. The facility failed to restart client D's Phenobarbital as ordered on 1/7/16.</p> <p>Interview with Director of Residential Services (DRS), LPN #1 and administrative staff #1 on 1/21/16 at 3:04 PM indicated client D had a seizure diagnosis. Administrative staff #1 and the DRS indicated there had been 2 medication errors in regard to the client's Phenobarbital. LPN #1 indicated she did not know why the staff did not restart client D's Phenobarbital on 1/7/16 as ordered. LPN #1 stated "I told them what to do but staff did not follow."</p> <p>Administrative staff #1 and the DRS indicated RN #1 was terminated due to the 12/24/15 to 1/2/16 medication error with client D's double dosing of the Phenobarbital on 1/10/16. LPN #1, administrative staff #1 and the DRS stated client D had been in the hospital</p>			

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W 0436 Bldg. 00	<p>and was discharged on 12/24/15 for Pneumonia and "Phenobarbital toxicity." The DRS indicated RN #1 transcribed the order on the MAR wrong and facility staff #1 caught the error on 1/4/16. LPN #1, administrative staff #1 and the DRS indicated facility staff had been trained in regard to medication administration. LPN #1 indicated she had trained staff on administering client D's medication changes and orders.</p> <p>This federal tag relates to complaint #IN00185316.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 1 of 4 sampled clients (C), the facility failed to assure client C's helmet was in proper working order.</p> <p>Findings include:</p> <p>During the 1/13/16 observation period</p>	W 0436	<p><b>W436</b> <b>Finding(s):</b> <b>1. "Based on interview, record review, and observation for 1 of 4 sampled clients ©, the facility failed to assure client C's helmet was in proper working order."</b></p> <p><b>Corrective Action(s):</b></p>	03/16/2016			

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	<p>from 3:30pm until 4:55 pm client C wore his protective helmet while sitting at the kitchen table. Client C was sitting in a chair and made several attempts to stand up from his chair. Staff #5 went and got a helmet and placed it on client C's head. The helmet had a chin strap that was held on by tape and would not stay secured around client C's chin. Client C was sitting at the kitchen table having a snack and a drink. Client C was not banging his head at this time. At 4:15 pm client C would take his helmet off and throw it on the floor and staff would pick it up and place it back on his head.</p> <p>Client C's record was reviewed on 1/20/16 at 1:26pm. Client C's May 2015 BSP (Behavior Support Plan) indicated "[Client C] wears a helmet when he begins banging his head. Staff will put the helmet on [client C's] head and fasten the strap. Staff will remove the helmet when he has stopped banging his head. [Client C] also wears his helmet when there are corners or hard objects he could hit his head on during periods of agitation. His helmet is removed after he has calmed and out of danger."</p> <p>Client C's 4/12/12 physician statement indicated this was the last time he had his helmet fitted or looked at.</p>		<p><b>Toensure that there all adaptive equipment/devices are in good working condition:</b></p> <p>1.TheResidential House manager will inspect client C's helmet weekly to ensure it isin proper working order. The Residential House Manager will document thecondition of the helmet weekly. If the helmet is not in proper condition theResidential House manager will contact the Residential house Manager and getthe helmet replaced with a new one.</p> <p>1.Allstaff located in the home will be trained on client C's helmet and theimportance of ensuring it is in proper working condition and what to do if itis not. Record of Training formswill be completed following staff trainings and will be submitted to theResidential Director for administrative oversight.</p> <p>-</p>				

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	<p>Interview with the Director of Residential Services (DRS) and Administrative staff #1 was conducted on 1/21/16 at 3:04pm. When asked if client C's helmet should be in good working condition, the DRS stated "yes."</p> <p>9-3-7(a)</p>				