

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901
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W000000	<p>This visit was for the investigation of Complaint #IN00152772.</p> <p>Complaint #IN00152772: Unsubstantiated, due to lack of sufficient evidence.</p> <p>Unrelated deficiency cited.</p> <p>Dates of survey: September 11, 16, and October 3, 2014.</p> <p>Facility number: 012527 Provider number: 15G802 AIM number: 201024860</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 10/10/14 by Ruth Shackelford, QIDP.</p>	W000000	<p>W368 Finding(s): a. "Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 3 of 3 sampled clients (A, B, and C) and 5 additional clients (D, E, F, G, and H)".</p> <p>Corrective Action(s): To ensure that all medications are administered as directed by physician orders, the following correction actions will be have been and/or will be implemented: 1) All staff working at the location of 112 East Westmoreland Drive (Westmoreland group home) were retrained on the agency medication administration policy on August 7, 2014. Refer to Appendix A for signed Record of Training forms. However, to ensure further comprehension of proper medication administration procedures, all staff located in the home will be re-trained on the agency medication administration policy. Refer to Appendix B for Record of Training form to be used. 2) All staff working at the location of 112 East Westmoreland Drive (Westmoreland group home) will participate in a simulated medication administration course in which they are to conduct a mock medication pass and</p>	

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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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W000368	administer placebomedications to a willing staff member under the observation of the ResidentialNurse. The Residential Nurse will use this time as an opportunity to furthereducate the staff individually on proper medication administration whilecorrecting inappropriate or unapproved techniques being exhibited by staff. Refer to Appendix C for Record of Trainingform to be used. 3) EffectiveOctober 11, 2014, to reduce the amount of missed or overlooked medications,medication packaging has been switched from individual medication pop-pack,medication cards to multi-dose dispel packs. This form of packing enables allmedications to be place in one dispensing cup and eliminates the need to removemedications from individual packages. Staff are to verify that all medicationslisted on the packaging are in the dispel pack prior to administering themedication to clients. Documentation of checking the medications is monitoredand verified by the Residential Nurse and the Residential House Manager on aroutine basis.	11/07/2014	

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	<p>Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 3 of 3 sampled clients (A, B, and C) and 5 additional clients (D, E, F, G, and H).</p> <p>Findings include:</p> <p>On 9/16/14 at 2:13 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 6/12/14 to 9/16/14 were reviewed. A BDDS report dated 6/17/14 indicated Client C "is prescribed 400mg (milligrams) of Seroquel (antipsychotic) XR (extended release) daily at 8AM. Last evening when [DSP (Direct Support Professional) #1] was passing 8pm medications, he noticed that the 6/16 dose of Seroquel had already been given. He called the house manager [HM], who had done the 8am medication pass for the day. She had also signed on the medication pack that she had passed it." The report indicated "the Residential Nurse was notified of the medication error, and informed the psychiatrist." The report indicated "no dose was given last evening. Normal dosing will resume today, and no adverse side effects were noted."</p> <p>A BDDS report dated 6/18/14 indicated</p>		<p>Finding(s):</p> <p><i>a. "Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 3 of 3 sampled clients (A, B, and C) and 5 additional clients (D, E, F, G, and H)".</i></p> <p>Corrective Action(s):</p> <p>To ensure that all medications are administered as directed by physician orders, the following correction actions will be have been and/or will be implemented:</p> <p>1) All staff working at the location of 112 East Westmoreland Drive (Westmoreland group home) were retrained on the agency medication administration policy on August 7, 2014. <i>Refer to Appendix A for signed Record of Training forms.</i> However, to ensure further comprehension of proper medication administration procedures, all staff located in the home will be re-trained on the agency medication administration policy. <i>Refer to</i></p>	
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	<p>Client D was prescribed "Bupropion XL (antidepressant, extended release) 150mg given daily at 8am, to aid in smoking cessation. The pill was not administered on 6/9/14."</p> <p>A BDDS report dated 7/11/14 indicated "[Client F] did not receive his Concerta (stimulant) 54mg on 7/10/2014 at the 8am medication pass. Direct support professional administered all other morning medications but the Concerta. This error was found on 7/11/2014."</p> <p>A BDDS report dated 7/20/14 indicated "Direct support professional did not give [Client D] his 4pm Oxcarbazepine 600mg 1/2 (half) tab (tablet), on 7/19/14. The doctor was notified and the doctor gave permission to give the medication @ (at) 8pm with his 8pm medication pass."</p> <p>A BDDS report dated 7/20/14 indicated "Direct support professional did not administer [Client H]'s 4pm Loratadine (for relief of symptoms of allergies) 10mg 1 tab (tablet) @ (at) 4pm and his Olanzapine (antipsychotic) 10mg @ 4pm on July 19, 2014. The doctor was notified and permission was given to administer the missed medications @8pm medication pass."</p>		<p><i>Appendix B for Record of Training form to be used.</i></p> <p>2) Allstaff working at the location of 112 East Westmoreland Drive (Westmorelandgroup home) will participate in a simulated medication administration course inwhich they are to conduct a mock medication pass and administer placebomedications to a willing staff member under the observation of the ResidentialNurse. The Residential Nurse will use this time as an opportunity to furthereducate the staff individually on proper medication administration whilecorrecting inappropriate or unapproved techniques being exhibited by staff. <i>Refer to Appendix C for Record of Trainingform to be used.</i></p> <p>3) EffectiveOctober 11, 2014, to reduce the amount of missed or overlooked medications,medication packaging has been switched from individual medication pop-pack,medication cards to multi-dose dispel packs. This form of packing enables</p>		

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	<p>A BDDS report dated 7/20/14 indicated "Direct support professional did not give [Client G] his 4pm Oxcarbazepine (anticonvulsant) 600mg 1 tab. The doctor was notified and permission was given to pass this medication @8pm medication pass."</p> <p>A BDDS report dated 7/27/14 indicated "Direct support professional forgot to give [Client B] his Topamax (anticonvulsant) 25mg 1 tab @ (at) 8am on 7/26/2014. The medication error was found @ 7:44pm and staff reported the missed medication."</p> <p>A BDDS report dated 7/30/14 indicated "[Client G] did not receive his 8pm dose of Vitamin E 400IU (units) @ his 8pm medication pass."</p> <p>A BDDS report dated 8/11/14 indicated "Direct support professional did nor (sic) give [Client D] his 8am medications before he left and went to a Special Olympic football game on 8/10/14. [Client D] missed his Benztropine (used to counteract side effects of other medications) 2mg 1 tab, Haloperidol (antipsychotic) 10mg 1/2 tab, Vitamin E 400IU 1 cap, Lamotrigine (anticonvulsant) 200mg 1tab, Cocqlace (sic) (stool softener) 100mg 1 tab, Propranolol ER (used in treatment of</p>		<p>allmedications to be place in one dispensing cup and eliminates the need to removemedications from individual packages. Staff are to verify that all medicationslisted on the packaging are in the dispel pack prior to administering themedication to clients. Documentation of checking the medications is monitoredand verified by the Residential Nurse and the Residential House Manager on aroutine basis.</p>	

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	<p>hypertension, extended release) 80mg 1cap (capsule), Lithium Carb (carbonate) ER (mood stabilizer) 450mg 1tab, Bupropion XL (antidepressant, extended release) 150mg 1tab. The residential nurse was notified and the doctor was notified."</p> <p>A BDDS report dated 8/21/14 indicated "Direct support professional gave [Client D] another housemates dose of Olanzapine (antipsychotic) 10mg 1/2 tab at the 8:00am medication pass on 8/21/2014. There were no other incorrect medications given." The report indicated "residential nurse was notified, the doctor was notified, there has been no adverse side effects. Direct support professional making the medication error will be counseled as per [facility]'s medication administration policy."</p> <p>A BDDS report dated 8/26/14 indicated "Direct support professional did not administer [Client E]'s 8pm medications on 8/25/14. Residential nurse was contacted and called the doctor around 11pm on 8/25/14 to notify that they were not given on time. The doctor gave approval for [Client E] to receive all of his 8pm medications late. [Client E] was given his medications."</p> <p>A BDDS report dated 8/27/14 indicated</p>						

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	<p>"[Client H] was not given his 8:00pm dose of Docqlace (sic) (colace, stool softener) 100mg 1 capsule."</p> <p>A BDDS report dated 9/6/14 indicated "[Client A] did not receive his 8pm medication of Trazodone (antidepressant) 50mg 1 tab QHS (given at each bedtime) until 9:25pm. QDDP (QIDP, Qualified Intellectual Disabilities Professional) was notified, residential nurse was notified, and doctor was notified of the medication being given late."</p> <p>On 9/16/14 at 3:03 PM during an interview, the QIDP stated she "knew" the group home had a "problem" with medication errors. The QIDP stated staff had been trained during orientation and staff who medication administration errors had been "retrained." The QIDP stated "some staff" had been "terminated" as a result of ongoing medication administration errors. The QIDP indicated staff would need more training to ensure medications were administered without error.</p> <p>9-3-6(a)</p>			